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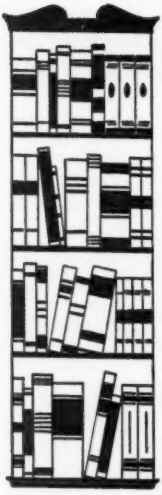

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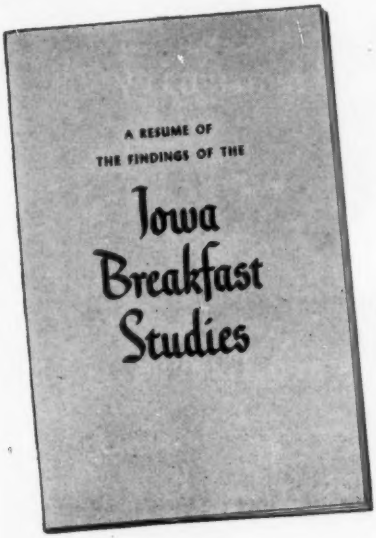

During 1948, 1949, and 1950, carefully controlled scientific studies were made on the effects of various breakfast habits in both men and women. The purpose of these studies was to learn the effects of skimping and skipping breakfast and to determine the optimal size of breakfast.

These experiments were conducted jointly by the Departments of Physiology and Nutrition at a prominent medical school. To appraise the effect of various breakfast habits upon physiologic responses specially designed equipment was used to measure choice reaction time, neuromuscular tremor, and maximum work output.

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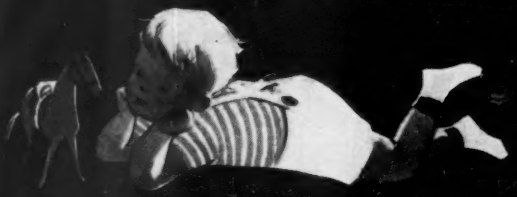

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

The Committee on Agreements for NLN

WE KNOW that you've been studying the proposed bylaws for the National League for Nursing, the final articles on structural reorganization, and the timetable on structure (page 298) to be ready to take action in June. You are probably wondering how plans can be made to merge four national organizations (the memberships of at least three of them will take action during biennial week) while their programs and services to members are continued without interruption and all the new work taken on.

The boards and staffs of AAIN, ACSN, NLNE, and NOPHN have been facing the same problem! Frankly, it would not have been possible without the hardworking Committee on Agreements for NLN which the four boards appointed early last summer. (See PUBLIC HEALTH NURSING, August 1951, page 407.) This committee is composed of two representatives of the AAIN, ACSN, NLNE, and NOPHN—the president of each organization, and one other member of each board appointed by the president. The chief executives of the organizations are ex-officio members. The American Nurses' Association, although not a regular member of the committee as it will not be merging into NLN, has named consultants to the committee who meet with the group regularly. The members of the Committee on Agreements are responsible to the boards that appointed them. All of their work has been carried out within the framework for structural reorganization as outlined by the Joint Coordinating Committee on Structure and approved by the Joint Board. Structure developments have been released through the nursing magazines as quickly as possible.

Between July and December 1951 the Committee on Agreements worked on materials for the boards to act upon at their January meetings—such as details about the proposed bylaws for NLN, plans for the proposed interim board (see page 301 for slate) for the interim steering committee for each division and department, for the interim nominating committee, and for the program for the first meeting of NLN now scheduled for June 20, 1952. They also worked out an interim plan for executive personnel.

Since the January board meetings the Committee on Agreements has, in addition, been making plans for the first meeting of the interim board for the National League for Nursing if the memberships bring it into being during biennial week. For example, the group is reviewing the present programs and

budgets of the merging organizations and preparing recommendations for the continuance of important work for the memberships and new board to act upon. At its first meeting the interim board will need to take action on how the work of the large joint committees assigned to the NLN will be continued during the fall of 1952. This work includes the programs of the Committee on Careers, the National Nursing Accrediting Service, and the National Committee for the Improvement of Nursing Services. The interim board will also need to decide just how such programs as the Joint Orthopedic Nursing Advisory Service, the Joint Tuberculosis Nursing Advisory Service, and the psychiatric and mental hygiene project are to be continued and how other important work and conferences scheduled for the fall are to be carried out.

In all of this discussion you note the word "interim" over and over. Yes, we must all realize that it will take at least a year after the memberships act for us to grow into being the complete new NLN. That's why a convention for NLN is planned for June 1953.

By that time, if the preliminary steps are taken by the memberships during 1952, all of NLN's members can meet and work together as one unit. A new board for NLN will be elected and so will new steering committees for all departments and divisions. The new councils of member agencies will have gone into action. The joint committee programs will be ready for next steps. All of the "interims" will then go out of existence—board, steering committees, nominating committee, and any other committee appointed by the interim NLN board.

The work of the Committee on Agreements is guided by the boards of directors and legal counsel for the organizations participating in it. *All of its recommendations are subject to the action still to be taken by the memberships of each organization involved.*

Merging four nationals—each with active programs—into an entirely new organization is a far tougher job than starting from scratch. But we all hope it will result in preserving the strengths of the old organizations and that new strengths will be quickly developed with the broadest possible participation of the memberships involved in the merger.

National Mental Health Week
May 4-10, 1952

NATIONAL Mental Health Week, observed in the spring each year, is part of the ongoing education program of the mental health movement. Its purpose is to make every American aware of his stake in mental health—to tell him how he and his neighbors, through their mental health associations, can work together to create both the conditions and facilities that will make for better mental health in their communities.

The slogan selected for the 1952 week is brief and to the point: *Mental illness: America's number 1 health problem. Let's face it so we can fight it.* It covers two important aspects of the work of the National Association for Mental Health. First, it calls attention to the magnitude of the problem and second, it sounds a call to action. Nurses who know too well what havoc mental illness plays can do much to stimulate community interest in this problem.

Emotional Stress As It Affects Civil Defense Nursing Activities

JULIA FREUND, R.N., MIRIAM WHITAKER, R.N., and JAMES S. MAY, M.D.

PART I

CIVIL DEFENSE education and training are designed to raise the level of individual and group tolerance of stress and to limit the number and severity of disabling emotional reactions. People show variations in their ability to tolerate stress and differ in their reactions to disaster. An individual's reactions are determined primarily by his biological inheritance and his life experiences. His reactions also depend upon what preparation he has had for the disaster, how well informed he is about what is happening, how effective leadership is, and what is required of him before, during, and after the emergency. Nevertheless, despite individual variations in behavior people en masse show a rather uniform overall reaction pattern at the time of and following a catastrophe.

During the last ten years a great deal of investigative work has been done concerning the reactions of both civilian and military personnel to disaster and to intermittent and prolonged stress. On the basis of research studies certain statistical and descriptive predictions can be made for any group surviving a flood, a devastating fire, a bombing attack, or another comparable disaster. Tyhurst and his associates have described three distinct but overlapping reaction phases which they have called *the period of impact, the period of recoil,* and *the posttraumatic period.*

At the time of and immediately following a major disaster most people are temporarily stunned. During this *period of impact,* lasting from a few minutes to an hour or more, people generally experience bewilderment, confusion, and emotional shock. There is a dulling of awareness and a blunting of feeling. Behavior is automatic and determined by habit rather than by reasoning. This mechanical behavior and apparent incapacity for feeling are protections against being completely overwhelmed by the catastrophe. It is to be expected that most people will be unable to respond to the emergency in a logical problem-solving way, although they can and usually will carry out activities in which they have been previously well trained and for which they have adequate direction.

Roughly three fourths of the people involved in a disaster, the so-called normal group, continue to be in a dazed condition for as long as an hour. For the remaining one fourth the immobilizing effect of the period of impact is of comparatively short duration and they reach the *period of recoil* more quickly than the majority of people. These "quick reactors" then become either the "cool, calm, and collected" leaders, who are able to size up the situation and make and carry out plans, or they react inappropriately with panicky flight, hysterical crying, or with other behavior which may be detrimental to them-

Miss Freund and Miss Whitaker are public health nursing consultants, Maryland State Department of Health. Dr. May is a psychiatrist, Maryland State Department of Health, and Deputy Chief of Mental Health, Essential Community Services, Medical Services Division for Civil Defense, Maryland. *This article is a section of The Suggested Content for the Training Program in Civil Defense Nursing, Maryland State Department of Health, Division of Public Health Nursing.*

selves or to the group. It is difficult to predict which individuals will be cool, calm, and collected. Some so-called nervous people may be able to rise to the occasion. These previously unidentified leaders should be sought out by rescue personnel and their abilities to function utilized in the care and treatment of others.

For the normal group the pattern of shock and bewilderment gives way more slowly to the reactions of *the period of recoil.* The release of suppressed feelings comes as a sudden wave of emotion and accompanies a lessened fear of immediate danger and a feeling of relative safety. There may be an awareness of anxiety and fear, sudden outbursts of weeping, and surges of anger with unprovoked tirades against everyone, including rescue workers who are trying to help. This is the time when most of the survivors are seeking shelter, arriving at first aid stations and relief centers, or being transported by stretcher or ambulance. Now there begins to be an awareness of the immediate past and a limited comprehension of personal involvement. However, events of the disaster are not seen in perspective and recall is still far from complete.

As people more fully grasp the reality of their survival and strive to achieve some emotional balance within themselves, they are able to express some of the feelings of which they were unaware during the period of impact. Pent-up emotions emerge and periodically engulf them. Consequently, people show a wide range of behavior which bears little resemblance to their usual behavior and is difficult to understand because it seems so inappropriate to the situation. It is important that rescue workers and medical personnel expect irrational behavior, recognize the purpose which such behavior serves in the restoration of emotional balance, and realize its temporary nature.

As is true in any personal crisis, there is a tendency to regress to a state of childlike dependency. Dependent behavior may be precipitated even in apparently self-reliant and self-directing people by any genuine act of reassurance or aid. There is a great need to be cared for and to be given things as tangible proof of being cared for. The importance of the giving and the nursing is not so much related to the actual kind of aid given as to the psychological meaning of being cared for. Personal belongings acquire special value because they reinforce the reality of survival, because they provide a link with the past, and because they help people to endure the totally changed world in which they now live.

Among survivors there is a strong need and a desperate desire to have close physical contact with other people, to talk about experiences, and to review them in the light of survival. They need group support and tend to congregate in bands of varying sizes, but group formation is based solely upon the need of survivors to seek comfort and reassurance from other people. Groups are, therefore, characterized by lack of organization and by instability, because people are unable to establish and maintain the give and take relationship essential for more stable group formation. The initiative for group formation must come from persons who are comparatively less involved in the disaster, who have leadership ability, and who are especially trained for rescue work.

At this time fear and anxiety may be expressed in rumors, which, once started, spread quickly and grow rapidly in size, partly as a means of expressing anger and resentment, partly as a device for self protection and wish fulfillment, partly as a relief for feelings of helplessness, and partly because rumors provide answers for questions which need answering. It is, therefore, of primary importance that people be informed authoritatively and accurately before, during, and following a disaster.

The posttraumatic period, continuing over days, weeks, months, or even years, is one in which a wide range of emotional reactions is to be expected. In contrast to the recoil period, when the individual first begins to face what has happened, he now begins to reorganize his life within the changed situation. More important than the external circumstances are the internal resources of the individual, his ability to relate himself to other people and to use help from them. An individual's ability to adjust is dependent

upon how personally disastrous the experience was and how similar to that of other people, how widespread the destruction was, and for how long he has had to maintain himself on an emergency basis. People who have lost little and have to cope only with community disorganization will have less adjustment to make than those whose losses are greater and more personal. The majority of people will continue to show emotional reactions to their experience for many months. To the extent that people have had serious personal losses we may expect continued anxiety, overwhelming fatigue, recurrent nightmares, prolonged grief, and psychosomatic illnesses to be some of the more common symptoms of the adjustment period. Adjustment proceeds gradually and unevenly and may be characterized by recurrent emotional upsets for which psychiatric help may be indicated. The small number of people who continue to show more serious symptoms such as uncontrollable rages, unrelieved depressions, and suicidal tendencies will need prolonged psychiatric treatment. For people who are never able to make a satisfactory adjustment the disaster experience may have been a precipitating rather than a causal factor.

Whatever psychiatric help is available during and following the disaster period should be used selectively so that the maximum number of people can receive such help. Nurses can be of assistance in referring people to specialized services as early as possible in the course of serious emotional disturbances.

Mass reactions

During periods of increased tension feelings are unusually communicable. Feelings of loyalty, responsibility, and group solidarity can be mobilized in times of crisis and maintained throughout periods of continued stress. People are capable of courage and endurance far beyond usual limits when leadership is effective, when strong motivations are present, when incentives are meaningful, and when preparation and training have made purposeful action possible. Group morale is not accidental but grows out of organized community efforts. Civil defense training decreases the feeling of individual helplessness and provides the strength of united efforts and the emotional support of the group. Practice in specific jobs provides the basis for automatic behavior in an emergency. Such practice should be in situations which simulate as nearly as possible the conditions under which people will work at the time of a catastrophe. The more actively people participate in civil defense preparation, and the better trained they are, the more confidence they will have in themselves and others, and the less need they will have to express their feelings of helplessness in behavior such as scapegoating and ridiculing which disorganize the group. After a disaster a well prepared community can reorganize itself and establish a kind of social equilibrium, even though personal and material losses have been great. However, an emergency kind of community organization differs from that existing under normal conditions in that a wide range of strong feelings which are usually diffused must be invested in group relationships which permit united efforts toward a single objective, that of group survival. In a time of crisis human relationships are relatively more important in sustaining people than are food and shelter.

In periods of stress everyone has an appreciable quantity of fear, anger, hatred, and resentment. These feelings can be powerful forces for group unity when opportunities are provided for their expression and use in activities which promote group survival. Hostile-angry feelings also serve a useful purpose when directed outside of the group against the common enemy or against the forces which caused the disaster and its resultant destruction.

Anger and hostility are likely to present problems for the defense effort only if something happens to displace these feelings from the enemy to members of our own working group, community, or nation. Displacement of this sort finds expression in excessive irritability, faultfinding, holding grudges against coworkers, suspicion and distrust of group leaders, resentment of authority, and even rebellion against the government.

Panic is the end point of such breakdown in group relationships and follows the loss of

group security. In panic the basic emotion is fear, which is most commonly expressed in flight. Mass panic behavior is the antithesis of organized purposeful group activity. Panic behavior is illogical and irrational and often highly dangerous to members of the group. It is usually accompanied by wanton destruction of property, unprovoked cruelty, and excesses of all kinds.

Panic reactions are likely to occur either very early or late in a disaster period. People in a group unprepared for a disaster may be so terrified when it occurs that they give way to panic. Early in any disaster period individuals who are most vulnerable to panic-producing fear must be identified and cared for outside of the group, since panic behavior is contagious and imitative. The use of fear and force to control incipient panic, although they may be temporarily effective, engenders more fear and the ultimate panic is even greater. In any group there are individuals who are almost totally unrelated to the community and the war efforts and whose antisocial and asocial behavior will be communicated to others and will lead to panic if the group organization breaks down. The control of vandalism, looting, sexual aggressiveness, and other asocial behavior will be the responsibility of the police, but all civil defense workers must be alert to the appearance of such behavior in order that it may be brought under early control. The best defense against early panic is preparation and training in the predisaster period.

When panic reactions occur late they are more likely to be the expression of accumulated resentments, feelings of repeated frustration, loss of confidence in leadership, and a sense of futility. The prevention of late panic is primarily dependent upon what happens during the disaster and the period of adjustment following it. Major factors in prevention are the strength of the relationship between the leaders and their team members and the conviction that the group is responsible for each person in it and that each person is responsible for the group. Also important is the provision of dependable information, particularly about the situation and efforts being made to improve it.

Delayed reactions and sustained stress

In any group there are a few individuals who do not respond immediately or fully to the stress situation, but may delay their response till much later. Such delayed reactions are essentially those of a postponed period of recoil. As we have noted before, the recoil period can be postponed but can never be circumvented. Recoil reactions are delayed for those people who have been prevented from facing the meaning of the disaster experience for themselves by either the sustained pressure of work or their own internal resistances. People normally work through their feelings about an experience at their own pace and make adjustments when they are ready. However, circumstances may either postpone a reaction or bring it about prematurely. When either of these things happens the recoil reactions are more disabling than they would have been if the person had been able to set his own time for reacting. They are more disabling because he has not had the opportunity to build up his defenses sufficiently to handle the feelings that are released and because physical and emotional reserves have been depleted by the stress of the disaster situation in which he is living and working.

The more of a physical and emotional deficit a person accumulates, the more subject to total breakdown he becomes. The longer a person works under stress without experiencing the reactions of the recoil period, the longer is the period of time required for his recovery. People who have carried responsibility well, at the expense of their own needs, suddenly are unable to carry on and may break on the job. Symptoms of this kind of delayed reaction are frequently psychosomatic in character and may appear to be of sudden onset, although they have been preceded by increased irritability, hypersensitivity to external stimuli such as noise, inability to concentrate and to make decisions, feelings of impending doom, and other symptoms which the individual has struggled to keep under control in order to go on working. Delayed reactions may be precipitated by relief from danger, by seemingly minor

(Continued on page 283)

Premies Are Human Beings Too !

DORIS M. GREENE, R.N., and LOUISE ZETZSCHE, R.N.

IN ONE NURSERY we see several tiny forms scarcely moving or breathing in their incubator homes. In another nursery there are some vigorous ladies and gentlemen well aware that their meal hour has come. What are the public health and the hospital nurses' responsibilities to these newest citizens arrived before their allotted time?

The problem of survival comes to mind first. The nurse's first responsibility is to help these babies in their struggles to keep alive. However, in this paper we are not going to discuss nursing procedures, but rather aspects of nursing care which should be discussed more often. For instance, what can nurses in hospitals and in public health services do to help prevent behavior problems frequently found in those prematurely born?

Let's start with the baby in the hospital. Suddenly rejected by his mother at six or seven months he still has definite needs for physical comfort, love, and security. At this stage of life it is difficult to separate these needs. The surroundings with which the child was previously familiar were warm, confining, and satisfied all his needs. Physical contact with his mother was continuous. The nursery staff must do everything possible to simulate this environment. An immobile incubator cannot completely substitute for the physical contact and the pleasant rhythmic movement the baby associated with his mother before birth. The nurse must become a mother figure. One way of helping the baby regain his lost security is to dress him in shirt and diaper and cover him with a sheet and spread or light cotton blanket while in the incubator.

As soon as the premie is able to make known his desire for food he can be fed as often and as much as he wishes. Thus he is early and frequently assured that his wants will be respectfully satisfied. A self-regulatory feeding schedule tends to make eating more pleasurable and therefore to lessen feeding problems when solid foods are introduced. A desirable practice is for the nurse to hold the infant snugly in her arms when feeding him. He enjoys being held and talked to before and after feeding, if time allows. In the Premature Center at the University of Colorado Medical Center our nurses have found a rocking chair appropriate.

Mothers seem to fall into two groups. They overprotect or they neglect a premie. Knowing this is a probable factor in the development of such behavior as excessive shyness, nervousness, feeding problems, and temper tantrums, the nurse is forewarned and should observe the mothers carefully to be ready to offer help whenever possible.

The very fact that the mother often returns to her home without her premature baby presents a problem. The infant must be considered a member of the family group from the very beginning even though he is separated from it. Lest the parents during a prolonged hospital stay forget that the baby is theirs, everything possible should be done to make it easy for them to visit their infant. Rather than have stated visiting hours let the parents come any hour of the day or night that is convenient to them. This may be nine or ten o'clock in the evening, after the father, returning from work, has had time to eat his supper and drive to town. Surely the hour will make no difference to "little Johnny," and this privilege could be a very important factor

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in arousing his parents' interest in his daily progress.

Such visits offer a fine opportunity for parent instruction. If mama and papa are interested enough to visit they are ready and eager to learn all they can about this rather awe-inspiring bundle. The nurse must receive them graciously, assume a personal interest in them and their baby, discuss his progress day by day, relate small incidents of interest, and keep them informed about his care and the plans for the parents' participation in the care.

Much can be done to strengthen family ties by proper response to telephone calls. Parents understand the expediency of waiting to telephone until after the babies have been weighed and the doctors have made their rounds. They also appreciate the opportunity of telephoning whenever they wish during the remainder of the twenty-four hours. Calls should be channeled directly to the nurse caring for the baby. Knowing the nurse's name, speaking to her daily or more often, make for a friendly relationship with hospital personnel and add to the peace of mind of worried parents. They can picture specific nurses interested in them and their baby, caring for him in a now familiar nursery. Nurses must realize that frequent calls from a family reflect extreme anxiety and that frequent reassurance is necessary. If these calls are met by a curt response the hard-gained rapport may be lost, as the family will naturally feel that the nurse lacks interest and understanding of its fears and worries. On the other hand, there are some parents who may need to be reminded to keep in touch with the hospital. The public health nurse can help them see what can be gained by visits and telephone calls to the nursery.

AT THE PREMATURE Center the mother has a chance to bathe and dress her baby in the hospital. She attends discussions on formula making and on the giving of vitamins. Sometimes mothers have group demonstrations; at other times individual demonstrations are given and the mothers return the demonstrations.

Mothers who have had several babies may

not feel the need for practice in bathing their babies but they often are worried about other problems. They are given the opportunity to verbalize these worries and to discuss them with the nurse. Maintaining the father's interest, soliciting his help in caring for the baby, managing grandparents who are overzealous or perhaps jealous of each other—such situations, and dozens of other frustrating problems which revolve around the new member of the family may come to light. Often solutions can be worked out.

The parents have opportunities for further learning in the hospital when the baby is taking his bottle feedings well and gaining steadily. They are invited to come to the nursery at mealtime and learn how to feed him. They may come as often as they can arrange it. Of course, these visits allow the nurses to discuss many aspects of child care in addition to proper feeding habits. Emphasis is placed on the premature baby's need for love and security.

When babies are admitted to the Premature Center the public health nurse in the area where the family lives is notified. The mother in the hospital is told about the nursing service available to her after her discharge. This frequently diminishes her apprehension. The public health nurse visits the mother soon after her return home to help make plans for the eventual homecoming of the baby. She evaluates the home situation, keeping in mind such basic needs as prevention of infection, proper feeding, and skillful handling. Being familiar with hospital procedures and criteria

for discharge and having information about the baby's birth weight and general progress, the public health nurse can estimate the length of the baby's stay in the hospital and plan her visits accordingly.

When the baby is discharged from the hospital the public health nurse is given a summary of his progress and care, his feeding schedules, et cetera. The summary includes points covered in parent education, demonstrations given, and notes about the parents' interest in the baby. Since the hospital nurses and the public health nurses have worked together on baby care and formula technics and on the points for parent instruction the mother is further reassured when the nurse visiting her uses the procedures she observed and was taught in the hospital.

Self-regulatory feeding schedules may cause difficulties in family adjustment. The premature baby in particular should have special consideration for individual variance in the matter of feeding routines. A mother may become unduly concerned if her child doesn't take all his feeding or sleeps past his usual feeding period. If the nurse is to help this mother she has to think about several points: What earlier experiences has the woman had with children and with feeding them? Has she had an older child who had been on a strict schedule? Is she a calm and relaxed person who is reasonably secure in her knowledge, or is she usually overanxious? Is she a methodical individual who may find it difficult to adjust to a child who is setting his own schedules? The mother who understands the basic principles underlying this method of feeding usually will accept it and put it into practice, and the nurse can do much to help her see that this method lessens tensions between herself and her baby and establishes a sound basis for future relationships.

The public health nurse's findings of her home visits before and after the baby is discharged from the hospital are reported to the hospital personnel. They aid in deciding when the baby may be discharged. If the home conditions are unsatisfactory the nurse may enlist the help of the medical social worker. Points that may come up for discussion are inadequate housing, insufficient income, family health problems, parental attitudes, and family tensions, all of which may determine the kind of care the infant will receive. On selected cases conferences are held at the office of the Denver VNS, in which the hospital nurses participate whenever possible. These conferences help define the responsibilities of the workers and go far in giving the nurses an awareness of one another's problems.

The public health nurse and the hospital nurse have a joint responsibility to the premature infant and his family. They must plan together to return a normal well infant to parents happy and secure in their knowledge and ability to care for him.

PREGNANCY AFTER FORTY

The postmature mother in her forties has had time to acquire pathologic pelvic and systemic conditions which may have some influence on embryonic and fetal development. Had the infant been born of the same parents twenty years earlier he might have had an entirely different gestational and social environment.

If the older patient develops no medical or obstetrical condition which complicates pregnancy she may experience a physical feeling of rejuvenation. Normal pregnancy is not a disease; it is a state of health.

In the absence of major physical abnormalities age has its greatest influence on emotional attitudes. Older women feel less certain about their reproductive capacities. They need liberal amounts of reassurance based upon carefully observed prenatal developments.

The patient and her obstetrician place a high premium upon a living infant. Both need confidence to carry them through the last few waiting weeks of pregnancy. In an uncomplicated pregnancy delivery should be as near normal as circumstances permit. The older parents' abilities to understand and appreciate the growing needs of their infant are based upon their emotional and physical health supplemented by education and experience.

From "Pregnancy after Forty" by John Parks, M.D., *Geriatrics*, November-December 1951.

A Small Official Agency Studies Public Health Nursing Costs

SYBIL P. BELLOS, R.N.

IN THESE inflationary days good administrative practices in public health nursing are of great concern to the administrator of a small official generalized service such as ours. We have achieved some success in increasing salaries for our twelve staff nurses during the past five years by changing our salary schedule maximum from $2,000 to $3,888. However, with the corresponding increase in budget we are more than ever aware of the importance of making our service more efficient and of knowing, in so far as possible, the cost of the services which are sold. If the spiraling trends continue how long will the community be able to provide all of the present public health nursing services?

Because we are a tax supported agency we are not faced with meeting our budget through earned income, but we must be prepared to have the past year's income scrutinized when the annual budget is presented for the next year. Revenue from services is returned to the Town treasury, and of course the larger the revenue from services sold, the smaller the amount of local taxes required to support the program.

The NOPHN method of cost accounting seems to be much more meaningful to a generalized program than the usual calculations we made previously to arrive at the cost per visit. We ought to know the unit costs of various services in order to evaluate our present practices, and we found we had several definite reasons for undertaking a cost study using this method.

We wanted to know the cost of school nursing service which the Department of Health provides for the Department of Education. At the request of the School Administration we had been providing certain services which we thought were not proper responsibilities of public health nurses. We knew that the cost study would not evaluate the quality of school nursing but thought that the cost of services now provided would strengthen our request to the Board of Education to change and eliminate some nonnursing functions.

We were providing a parttime industrial nursing service for which we were being reimbursed on the basis of our cost per visit. We had to know the actual cost per hour since we charge industry on the basis of time spent in the plant. We were striving to increase the number of expectant mothers and fathers seen in classes and to decrease routine home visits to antepartal patients. Most of the patients in our community receive medical supervision from obstetricians who refer patients to the classes. We wanted to know the unit cost of the class session in order to compare the cost of service to the patient in the group with the cost of service to the patient at home.

Time spent in the office for recording, planning clinics, telephoning agencies and physicians is always of concern to the administrator. How much office time is reasonable? In the system formerly used this time was lumped together as office time and reallocated by rough percentages to the separate services of the agency. By using the latest method we are able to charge the pre- or postactivity directly to a definite cost center.[1] For ex-

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[1] Reid, Mabel. Story of the new NOPHN cost analysis method. PUBLIC HEALTH NURSING, July 1950, v. 42, p. 409.

ample, time spent in preparing for mothers' classes is allocated to that particular cost center, time spent in preparation and post-activity for the tuberculosis clinic and for the child health clinics is charged to those cost centers.

We were accepting some students for two or four months from New York University, graduate nurses working for degrees in public health nursing. We were beginning to plan for an affiliation of two months with the local hospital for collegiate basic students. Naturally, we had to know the cost of the present student program in order to complete future plans.

Preparation for the study

Before attempting the cost study our Board of Health was faced with some administrative decisions. We purchased the manual and studied it.[2] It seemed to us that the tabulation and compilation of time sheets were too big a job to be taken on at that time by our small office staff. We found also that we needed counsel from NOPHN in deciding the length of time and the best season of year for the time study.

After securing this help we found it necessary to add other cost centers so we'd know the costs of our entire program, so we selected a month when our complete program was functioning. We also learned that we could purchase tabulation service from IBM as well as help from the NOPHN on interpretation of the data, if this were needed, for $200. We realized that if we attempted to do the tabulation in our office the time factor would make it as expensive as purchasing service from IBM. The Board of Health approved the entire plan and agreed to request the additional necessary appropriation from the Board of Estimate. When the request was presented to the finance board with an explanation of the purpose of the cost study we found that businessmen, well understanding the need for accurate cost accounting, approved the appropriation.

The preparation of the staff for the time study was then begun. The purpose of the study was outlined. We secured the forms for the analysis from NOPHN and entered the codes for the additional cost centers. A committee of staff nurses reviewed the time study instructions and presented them to the staff. The committee emphasized that accurate time-keeping was essential if accurate costs were to be obtained. The nurses were told that time sheets would not be used by the administrator or supervisor as a check on their daily work, that a code was provided for personal activities during the day. We spent two days practicing and reviewing sheets for correct coding before we began our actual time study on May 1, 1951. The staff accepted the assignment as a new project which would last a month and cooperated willingly. Once they understood the reason for the study they entered into it wholeheartedly.

Results

After the cost study was completed we discovered some interesting facts about our agency: The cost of the nursing service given in the schools was 29 percent of the total expenditures of the agency. This figure rose to 36 percent when home visits made to school children were included. The cost of the industrial nursing service was $3.15 per hour and $4.73 a visit, considerably more than our charge to the plant. It is interesting to note that when our cost study was reviewed by the manager of the plant he was impressed with the businesslike method of cost accounting and stated that the industry expected no free service from us.

The average cost of all home visits was $2.89; the most expensive visit was to the antepartal patient, $3.28, and the least expensive, the school health supervision, $2.72. The average unit cost of mothers' class attendance was 59 cents. We found that each "not home" visit cost the agency $2.01. With 634 such visits in one year there was a wasted expenditure of $1,277.39. We know the unit cost of our child health conferences and tuberculosis clinic. Overhead costs were 66 cents per hour, which seemed high to the administrator. Upon inquiry we found this compared favorably with other agencies.

[2] National Organization for Public Health Nursing. Cost analysis for public health nursing services. 1950. New York, NOPHN.

Staff education, including formal staff meetings and institutes as well as planned conferences with staff and supervisor, accounted for 4.4 percent of our total budget or $22 per month per nurse for nine months per year. We were gratified to know that with the exception of some community functions the supervisor was directing her entire activity to guidance of students and staff.

The study of our student program was probably not conclusive, as it was based on the fourth month of the affiliation of two students and included the supervisor's evaluation conferences with students and with senior nurses. We know that provision for a good student program by a small agency is expensive. We also realize that it is stimulating to the staff. However, we shall have to consider costs and expect to give this further study. The new collegiate basic program in our local community hospital presents a challenge to both agencies to work together in providing the public health nursing affiliations with equitable distribution of cost. These are some of the facts which our cost study revealed.

We now have data to substantiate the cost of services sold and to point the way toward more efficiency in some areas. We have hurdled the gap from the old method to the new method and we have found the new method of cost accounting stimulating.

Operation: Costs

A progress report on the NOPHN *cost analysis method*

MARY ELIZABETH BAUHAN

ARE YOU INTERESTED in having useful reliable information on the cost of operating your service? Would you like to know in what activities nursing time is spent? The NOPHN cost analysis provides the answers.

Since 1949 when the method was tested in seventy-three public health services and put into practice agencies in all parts of the country have used it. We know that forty services have completed analyses or are in the process of completing them at this writing. Some of the seventy-three that were in the testing project have done later analyses and now have the benefit of comparable data. Several agencies have found the information so useful that they plan to repeat the analysis annually.

Mrs. Bauhan is the NOPHN *statistician.*

From all indications 1952 promises to be an active year in cost analysis work. Several large agencies—among them two state agencies—and quite a few smaller ones expect to do analyses this year.

The reason most often given for undertaking this kind of study is the one that started the agitation for a new method back in 1946—the need for more accurate cost data in order to establish a cost for each service and show the factors that determine the cost. Other reasons fall into the following groups: (1) the need for factual data on which to figure budgets and establish a selling price for different services (2) detailed information to substantiate requests for funds from community chests, local cancer societies, and other special service groups (3) time and cost information on the present agency program to

help decide whether a new service might be added or might replace one already in operation (4) information on the distribution of nursing time to see where it is being spent.

Comments from the users

Agencies commenting generally on the method point to the administrative value of the analysis, to the overall view it gives of the total service, and to the fact that data are available for each activity in the total program. However, some administrators have been more specific. One health officer said that the clarification of functions which resulted from planning the time study was worth the whole undertaking even if that were the only result. A city VNA was able to obtain an increase in state reimbursements for visits to crippled children by showing the actual cost of these visits, and a supervisor was able to prove by her time study that she was spending too much time in general office work at the expense of her supervisory duties.

Other developments

During the past two years there have been some interesting developments. A new project, Analyses of Special Cost Items in Public Health Nursing, is expected to answer some of the questions raised during the application of the method. The project covers student costs, costs of specialists and consultants, selection of the time study period, and isolation of public health nursing expenditures in official agencies.

In April 1951 the Metropolitan Life Insurance Company and the John Hancock Mutual Life Insurance Company agreed to accept for review nursing costs for home visiting computed by the new method. This means that an agency wishing to use this method does not also have to compute costs by the method formerly acceptable to the insurance companies in order to claim reimbursement from them.

Educational institutions have expressed interest in the method. An NOPHN staff member visited New York University, Johns Hopkins University, Harvard University, and Columbia University to talk to students enrolled in public health courses.

In 1950 the USPHS Division of State Grants gave consultation to state health departments interested in using the cost analysis method. Organizations in other fields have inquired whether the method is applicable to their services. Among these organizations are a family service agency in New York, a large urban board of education, and a county sanitation department.

Services available from NOPHN

NOPHN offers statistical computation service and consultation service and also supplies the forms needed to make an analysis. We can arrange to compile your time study and cost study data or do your complete analysis. Preplanning is an absolute "must." In fact, this is one of the most important parts of the process.[1,2] We can help you with this planning. Write to NOPHN or, better, if you are in our vicinity come in and see us. We may be able to arrange for field visits under the usual field consultation policy.

If you are not clear about the details of the method you'll find the manual, Cost Analysis for Public Health Nursing Services,[3] helpful. It contains a step-by-step analysis of costs in a hypothetical agency.

REFERENCES

1. Bellos, Sybil. Small official agency studies public health nursing costs. (in this issue) PUBLIC HEALTH NURSING, May 1952, v. 44, p. 256.

2. Reid, Mabel. The visiting nurse service of New York is cost conscious. PUBLIC HEALTH NURSING, March 1952, v. 44, p. 137-139.

3. National Organization for Public Health Nursing. Cost analysis for public health nursing services, 1950. New York. Available from NOPHN, 2 Park Avenue, New York 16. Price $2.

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Take Your NOPHN Membership Card to the Convention.

Midwifery on the Gold Coast

MARY MILLS, R.N.

VACATION trips are always exciting, and certainly one of the most interesting I have had was my visit to Accra, bustling capital of the Gold Coast. I took the opportunity to make the trip when I was stationed in Monrovia, headquarters of the USPHS Liberian Mission.

True to its name the Gold Coast is still a source of gold. I did not get to any of the mines, but I did see any number of the countless small coco farms when I was in the interior, and I can well believe that the Gold Coast produces over a third of the world's supply of coco, as my hosts informed me. Besides gold and coco the country's leading exports are manganese ore, timber, and industrial diamonds.

One of the sights in Accra is historic Christiansborg, official residence of the Governor. This huge old castle, high on a cliff which juts out over the ocean, dates back to the seventeenth century when it changed hands more than once as early Danish and Swedish traders fought to hold it.

Since my main reason for coming to the Gold Coast was to see the nursing and midwifery facilities I spent most of my time in Accra visiting the Maternity Hospital, the Nurse Training College, and the Gold Coast Hospital. They are attractively situated and their spacious grounds are colorful with brilliant tropical flowers. The white stucco buildings are modern and well equipped.

Miss Mills was chief nurse in the U. S. Public Health Service Mission in Liberia. She was cited recently for her work in extending public health nursing services in Liberia.

The Maternity Hospital in Accra, where students receive their midwifery training, is only a block or so from the Gold Coast Hospital. Although the capacity of the Maternity Hospital is seventy-five beds it is seldom possible to keep admissions down to that number, even with patients limited to primiparas and those with complications.

The complications of pregnancy remain the same, of course, whether in America, Africa, or any other country. For example, I saw a hydatiform mole and a patient with a ruptured ectopic pregnancy when I was there. In addition to births at the Maternity Hospital other babies are delivered by private and government-paid midwives at home.

The Midwifery School is directed by a sister tutor-nurse who is trained in midwifery and who has had considerable experience in the field, an assistant nurse midwife, and the nursing and medical staffs. The two sisters are Europeans and there are an African doctor and a European doctor. The nursing staff is African.

The midwifery training programs are geared to meet the particular needs of the country. Since the school was opened, about twenty-five years ago, it has had to offer two courses, one for graduate nurses and one for girls unprepared in nursing. The latter program is expensive, as the course requires two and a half years. The graduate nurses get their midwifery training in from fifteen to eighteen months. As nursing programs are being expanded the Midwifery Training School faculty hopes more graduate nurses will study midwifery in the future. The present need for midwives is greatest in the hinterland, where the biggest share of the Gold Coast population lives. Young women from all parts of the interior are encouraged to prepare themselves in midwifery in the expectation that they will return to practice in their home sections.

Some of the midwives have their own nursing homes and are permitted by the Medical Services, the agency responsible for their supervision, to admit their patients for delivery and care. I visited some of these homes, which range from simple to fairly elaborate in their buildings and equipment.

The Medical Services, which planned my most pleasant and profitable ten-day stay in the Gold Coast, arranged a day in the interior for me with the chief matron on one of her periodic visits. During this trip I saw two general hospitals and a station for patients suffering from Hansen's disease (leprosy) where the new drugs are being used.

Supervision of midwives has not yet been extended to the interior or rural areas because of the limited number of trained midwives. Outside of the cities babies continue to be born the same old way—with the help of a friend, a good neighbor, or an untrained midwife who has inherited the trusted art which is often handed down through the tribe from one generation to the next.

A Mother Writes About Natural Childbirth

The newer concepts in maternity nursing have been initiated and stimulated by expectant parents. The requests for preparation for labor and for rooming-in have increased rapidly. Many happy well adjusted individuals who have participated in natural childbirth and rooming-in programs have told of their sense of wellbeing and security. This letter gives a careful evaluation of the experience of a primigravida in one of our large university hospital clinics. Comments such as these should assist all who serve the mother to see themselves as others see them.

I HAVE WANTED to write this letter to the hospital—and of course all the staff—for some time. However, the first weeks at home with a first baby have been busy beyond anything I ever imagined or I had been told. Perhaps the problems have been caused by my own makeup. At any rate, pregnancy and birth were nothing compared to this. No one can tell you what a twenty-four-hour job means: how to get to sleep quickly so that the sleep zones between feedings will count; that it is a real fight to win out with the breast feeding when the baby is big, healthy, voracious, and mama is overanxious; that if he breathes quietly you don't have to run to see if he is dead, and so on. You just have to go through it and find out it is living to the hilt and probably worth it in spite of everything.

You undoubtedly knew from my enthusiasm at the hospital how much I appreciated my experiences there. Above all, I want to express my admiration for the way the clinic is conducted. Over a period of eight months I felt complete trust in the medical authority of the doctors, nurses, and auxiliary staff. And on the psychological side, I think it is a rather unique achievement that I and the many other patients I talked to always felt a sense of individuality and dignity in our contacts with the obstetrics staff. It is to their credit that this was so even when I must have been the two hundredth patient in a morning.

And I certainly wish to express my gratitude to the doctors who delivered Michael. I know they made the birth as easy as possible for mother and baby. They maintained complete respect for my wishes in regard to the methods I had learned in relaxation classes and were quite receptive to having my husband in the labor room—all this in spite of the possibility that they may or may not have been receptive to so-called natural childbirth. My husband and I were impressed

with the authority and calmness of the head nurse on the delivery floor.

And last, I want to thank the nurses on the postpartum floor. They made rooming-in very worth while and were entirely sympathetic and helpful to an overeager mother whose story they'd undoubtedly heard all too often.

The hospital is of course being exceptionally thorough in its help to prospective mothers in offering the series of relaxation classes at the nominal fee charged clinic patients. As far as my experience during labor was concerned I found the breathing exercises very helpful up to a point, and that point was fairly well along in labor. After that, it was difficult for me to be sure at just what stage I was and therefore what I should be doing. Certainly abdominal breathing was impossible. It was unfortunate that no one definitely sympathetic toward "prepared mothers" was present during Michael's birth. I felt a little like a pioneer at a time when I hadn't the least desire to put on a Carrie Nation act among people who may or may not have felt a bit of chicanery was involved.

I value the relaxation classes not only for the use I was able to make of the exercises but especially for the knowledge I gained of just what was happening and how long it would last. I cannot overemphasize the value I placed on the calming influence of that knowledge. There is inestimable help in the potent awareness of a job to be done; and once in the delivery room with a mirror for a clear view I could see the pending birth. I wanted to work, I was excited, and pain was thereby lessened—and I did see the birth of my own baby. If all proceeds normally, why should anyone take that alert consciousness of the experience away from a woman?

From the psychological point of view I think a great deal may be said for the simple act of attending the relaxation classes. I know that as a prospective mother I gained much by associating with other prospective mothers. There can be no neurotic dwelling on oneself. Pregnancy gains the healthy perspective of seeing many in the same boat and watching their reactions.

As far as the transition period is concerned, I found it unfortunate that in the classes we learned to look upon it as "difficult" or "uncomfortable." For me that period was just plain painful—in a word, it *hurt*, and why not admit it? It becomes a lot easier to take or to ask for sedation if you're sure you won't be put out completely for any period, no matter how short. As a result of the class euphemisms I had honestly expected to be mildly uncomfortable. Unprepared, I let out a few yells which, for no good reason, I find exceedingly embarrassing now.

And above all, I can't imagine going through birth without my husband. It's been our baby from the beginning and no act will ever do more for marital security than the experience together. And progress toward marital security is a lot to give a baby.

Yes, I hope to come back to the hospital again and have my next baby in more or less the same way.

Drawing by Edna Knowlton, R.N.

The Public Health Nurse in the Richmond Home Care Program

ABBIE I. WATSON, R.N.

THE RICHMOND Home Care Program has been in existence since July 1, 1949. It functions administratively under the Richmond City Department of Public Health and is closely integrated with the Medical College of Virginia.

The objectives of the program are threefold. The first is to provide a good quality of medical service to city residents who are financially unable to secure such services for themselves. A second objective is to give young medical students and young physicians an opportunity to see patients in their homes where they develop an awareness of the social and environmental factors involved in the practice of medicine in the home. A further objective is to provide an opportunity to study the social status of this group and the relationship between illness, socioeconomic status, and emotional states.

Nursing objectives are to give good nursing care under definite medical direction, and to familiarize young physicians and medical students with all facets of nursing care to bring about a deeper appreciation of the contribution which the public health nurse can make in maintaining and restoring family health.

Before discussing the manner in which the public health nurse functions in the program a brief account is given of the origin and operation of the service.

For many years home care service for the needy in Richmond had followed the "City Poor" type of program found in many cities. Home medical service was rendered by six parttime physicians. There was no continuity of service, as the doctor usually visited the patient only once unless he was specifically called back. He did not see the patient in the outpatient department of the hospital or in the hospital ward, nor did he receive reports of services given.

The present Home Care Program came into existence as a result of recommendations made by the Richmond Area Community Council following a study conducted at the request of the Richmond City Department of Public Health. The participation of this group in the initial planning of the program has been a factor in the effective use of the facilities of community health and social agencies in providing for medical care, making available a greater variety of specialized services to this group of patients.

The program was made possible through a grant from The Commonwealth Fund and is jointly financed by that foundation, the city of Richmond, and the Medical College of Virginia. Approval of the program was obtained from the Board of Health, the Richmond Academy of Medicine, the Medical College of Virginia, and the City Council. The service is housed in the outpatient department of the Medical College of Virginia Hospital.

This program functions as a part of the overall Medical Care Program of the Richmond City Department of Public Health, which has the financial responsibility for providing for the total care of the sick through hospitalization or medical supervision in the home, including clinic services, nursing care,

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housekeeper service, and provision of sickroom equipment. These services are provided to other than welfare recipients only when funds are available.

The medical staff consists of three physicians who are on the Medical College faculty, one of whom is the clinical director. These physicians supervise the two residents from the Medical College house staff who are assigned to the service for two- or three-month periods and the eight senior medical students who are assigned for three-week periods. The director of the Health Department is responsible for the overall direction of the program.

The patient is often first brought to the attention of Home Care by a request from the family or by a referral from an agency, clinic, or local hospital. The majority of referrals are initiated by the patient or his family. Now that the program is established and its facilities are better known, community health and social agencies are referring an increasing number of cases.

Medical care is provided on the basis of medical needs of each patient. It is continued in the home as long as needed and may be augmented by consultant services obtainable through the Medical College of Virginia clinics. Arrangements are made for the patient to attend a clinic or the consultant visits the home. Patients are often discharged to clinic care with a minimum of home visits.

Hospitalization for acutely ill patients is arranged by the Health Department Bureau of Medical Care at one of the Medical College of Virginia hospitals. The patient is later discharged to his home with Home Care continuing medical supervision or, if chronic or convalescent care over a period of time is indicated, he is transferred to a local hospital equipped to provide the type of care he requires. The Home Care physician follows the course of treatment of the patient during the period of hospitalization or during the period the patient attends the clinic. He visits the hospital ward and receives clinical reports on the progress of the patient.

Clinical case reviews are held in the form of conferences with the students twice a week. At these conferences every case admitted to the service is carefully reviewed from the clinical, social, and public health viewpoints. These conferences are attended by the clinical director of the program and/or his senior consultant, the director of the City Department of Public Health and/or the assistant director, the social service consultant, supervising nurses from the voluntary and official nursing agencies, and by all junior staff men and residents in the Home Care Program. This system of teaching, while admittedly expensive from the monetary viewpoint, has proven to be of great value in the indoctrination of medical students in the art and practice of medicine and community and environmental medicine.

Social aspects of program planning are handled by a medical social consultant. She works with medical students, residents, and physicians on the Home Care staff, as well as with public health nurses, social workers, and students of the two latter groups. In addition, she is responsible for the development of working relationships with community agencies which are participating in the overall program.

Nursing service in the home is provided by community public health nursing agencies. Patients in need of nursing care or treatment are referred to the Instructive Visiting Nurse Association of Richmond. Those primarily in need of services which usually fall within the jurisdiction of the official agency are referred to the Nursing Division of the Richmond City Department of Public Health. In the South Richmond area all patients requiring either nursing care or supervisory visits are referred to the South Richmond Community Nursing Service. This service, jointly sponsored and operated by the Richmond City Department of Public Health and the Instructive Visiting Nurse Association, offers a family health service to the community and is equipped to render a total nursing service to the patient and his family.

The Richmond City Department of Public Health has a contract with the Instructive Visiting Nurse Association which provides for payment at the cost per visit rate for nursing service given to indigent city residents. Similar contracts are in effect with the Family Service Society for housekeeper service and

with the Sick Room Loan Chest for sickroom equipment.

Patients are referred for nursing service through the referral system already in use by Richmond health agencies. Referrals are initiated in writing by the physicians on the form, Communication Between Health Agencies. The public health nurse also uses this form for periodic reports on the condition of patients under care and for requests for additional information or orders. Referrals and reports made by telephone are followed by written confirmation. All are filed in the Home Care record. When the family requests nursing service orders are secured from the physician.

The public health nurse is a vital part of this program. In addition to giving nursing service in the home she is a member of the Home Care team and attends the clinical case reviews and participates in the discussions. For the most part attendance is limited to supervisors although a limited number of staff nurses have attended the conferences in rotation in order to gain a better appreciation of the total program and to participate in the discussion of cases under their supervision.

The IVNA has often found it advantageous to hold case discussions on active cases with involved social and nursing problems. These conferences are usually initiated by the staff nurse and are attended by members of the Home Care staff and by social and health workers active on the case. On occasion they are held to demonstrate to public health nurse students the teamwork approach to problem-solving and the effective use of community resources. These discussions have resulted in a more realistic view of the problems involved and in a general understanding of how each agency can best contribute to the overall planning for the patient. Medical students attending such conferences gain a better understanding of the effective use of community resources and the role of the public health nurse in a community health program.

A large majority of patients in need of nursing service are referred to the voluntary agency and a smaller number to the official agency. The above distribution of services is not considered a problem as it is expected that in the very near future the combined program now in operation in the South Richmond area will be extended to cover the whole city. In view of these plans the following analysis of nursing services is based mainly on a citywide rather than an agency basis.

According to a statistical study made on 3,441 cases of the 3,500 patients seen by Home Care during the thirteen-month period from November 1949 to December 1950, we found that the program served 1.5 percent of Richmond's population of 230,310 people. This represents 7 percent of the white popula-

TABLE 1. Age Distribution of Home Care Patients, Nursing Cases Referred, Nursing Visits, and Average Number of Visits per Case November 1949 to December 1950

Age in Years	Total Patients		Nursing Cases		Nursing Visits		Average Number
	Number	Percent	Number	Percent	Number	Percent	Visits per Case
Under 1	206	6.0	9	4.5	21	1.6	2.3
1 - 4	850	24.7	10	5.0	11	0.8	1.1
5 - 9	348	10.1	7	3.5	4	0.3	-
10 - 14	188	5.1	2	1.0	6	0.5	3.0
15 - 19	171	5.0	4	2.0	6	0.5	1.5
20 - 29	346	10.0	23	11.4	141	10.8	6.1
30 - 39	294	8.5	14	7.0	120	9.2	5.0
40 - 49	238	6.9	14	7.0	207	15.9	14.8
50 - 59	209	6.1	26	12.8	171	13.1	6.6
60 - 64	118	3.4	14	7.0	59	4.5	4.2
65 and over	473	13.7	78	38.8	555	42.7	7.0
All ages	3,441	100.0	201	100.0	1,301	100.0	6.5

tion and 3.2 percent of the nonwhite. Of the total cases seen 1,076, or 31.2 percent, were white and 2,365, or 68.8 percent, were nonwhite. Approximately one third of the population of the city is nonwhite. Of the white patients, 44.9 percent were male and 55.1 percent were female; 37.2 percent of the nonwhite were male and 62.8 percent were female.

Of the Home Care cases under medical care during this period 201 cases, or 5.8 percent, were referred for nursing care. The distribution according to race and sex follows the general pattern of the total studied: 73, or 36.3 percent, were white and 128, or 63.7 percent, were nonwhite. Likewise, 42.5 percent of the white were male and 47.5 percent were female, and 32 percent of the nonwhite were male and 68 percent were female.

It can be seen from table 1 that the largest group of patients, or 24.7 percent, served by Home Care during this period was in the age group 1 to 4 years, and that the second largest group was 65 years and over, or 13.7 percent. Only 5 percent of the total were referred for nursing care, and 0.8 percent of the total 1,301 nursing visits were to children in the 1 to 4 years group but the 65 years and over group constituted 38.8 percent of the cases referred for nursing care and 42.7 percent of the nursing visits. This is no doubt owing to the more acute and generally shortterm nature of illness among the young children and the chronic and longterm illnesses in the aged, which often require nursing care over an extended period of time. This is emphasized by a study (see table 2) which was made on 116 chronic cases during the twelve-month period July 1, 1950, to June 30, 1951. This study shows that 46, or 39.7 percent, were 65 years of age and over.

To return to table 1, one sees that patients in the 20-29 age group represented 10 percent of those under medical care, 11.4 percent of those referred for nursing care, and 10.8 percent of nursing visits. An influencing factor here is the early discharge of maternity cases from St. Philip's Hospital. Home Care is frequently called in to give further medical supervision.

The average number of visits per case for all patients referred for nursing service was 6.5. This is on a par with that of the total nursing service of the voluntary agency. The need for nursing service for Home Care cases increases with the older age groups both in regard to the number of cases referred and the amount of service given. The above trend is more pronounced in the 65 years and over age group.

The needs of patients referred for nursing service vary. Many families can assume full responsibility with a minimum of assistance from the nurse. Others are in need of health guidance or nursing care over a long period of time and may also require extensive medical and social services to facilitate longrange

TABLE 2. Age Distribution of Patients According to Diagnosis Referred to the Instructive Visiting Nurse Association By Home Care, July 1, 1950, to June 30, 1951

Diagnosis	Age in Years							
	Under 20	20-29	30-39	40-49	50-59	60-65	65 and Over	Total
Tuberculosis	1	3	2	1	1	2	2	12
Cancer		1	3	4	4		7	19
Rheumatism and arthritis							1	1
Diabetes				5	3	1	3	12
Anemia							2	2
Cerebral hemorrhage					4	2	4	10
Diseases of circulatory system		1	5	9	6	7	23	51
Nephritis		1			1			2
Paraplegia	1	1	1					3
Senility							4	4
Total	2	7	11	19	19	12	46	116

planning for care. It is often found that skilled nursing care is required to enable the patient to remain in the home where he will be happier than in the hospital. It is then important that considerable support and encouragement be given to the family by the physician, nurse, and social worker. The manner in which members of the Home Care team function in this program is illustrated by the following case summaries.

Mrs. S, an elderly diabetic, under insulin therapy irregularly for several years and handicapped by partial blindness and a leg amputation performed three years previously, was referred for nursing care. This woman made her home with a sister, a diabetic, also under insulin therapy, who was at the time of the referral somewhat resentful of the patient's dependence upon her. She felt that she could not assume the responsibility of administering the insulin to the patient, as she left home early each morning to go to her work as a domestic.

This case was discussed at a clinical case conference at which time it was advised that (1) the medical social worker make a social evaluation and give direct service if indicated (2) the nurse continue to encourage the sister and the patient to assume responsibility for care (3) visiting housekeeper service be requested (4) close medical supervision be continued with referrals to physical medicine and the eye clinic as soon as the patient could accept this. Through the joint efforts of the social worker and the nurse a plan was worked out with the patient and her sister so that the sister would do the urinalysis each evening and prepare the insulin before going to work each morning for the patient to administer to herself later. After the procedure had been demonstrated by the nurse, and Mrs. S had actually administered the insulin to herself under supervision several times, she was able to follow through on this plan with encouragement from the physician. Soon Mrs. S agreed to a referral to the eye clinic and later asked to be sent to physical medicine to learn to use her "wooden leg." As she learned to walk and her physical condition improved she became more independent and encouraged. She gradually developed a better attitude toward her illness, which brought about an improved relationship with her sister. After a three-week period this case was closed to nursing service. Close medical supervision was continued.

Mr. F, a young man diagnosed as having advanced cancer of the bladder, was referred for terminal care. Mr. F had refused hospital care as he preferred to remain at home with his wife. The public health nurse visited the home and found facilities adequate for care. She is now making daily visits for the purpose of giving skilled nursing care. At the clinical conference the nurse reported that Mrs. F was extremely anxious about her husband's condition and was unable to hide her anxiety from him. She needed assistance in planning for the future, from a financial angle and from an emotional angle. The medical social worker was asked to make an evaluation. She learned through the Retirement Insurance Company, in which Mr. F had participated, that he was entitled to disability insurance as long as he lived and that his wife was entitled to a pension after his death. The amount of the insurance was enough to cover the immediate needs of the family. Mrs. F has leaned heavily on the social worker and the nurse for assurance, as she has no family or close friends near to help her through this crisis. She has made as good an adjustment to Mr. F's illness as can be expected. The husband and wife are devoted to each other and she gives him excellent care.

Mr. and Mrs. D, an elderly couple, were first known to the IVNA several years ago when Mrs. D was diagnosed as having hemiplegia. She was at that time under the care of a private physician. The nurse has been called in periodically since when nursing care was needed. When Mr. D became ill the private physician gave permission for Home Care to take over the responsibility for medical care, as the family was then receiving welfare assistance. Mr. D was referred for nursing care with a diagnosis of arteriosclerotic heart disease and chronic glaucoma. The nurse visited the home and found Mrs. D, who is handicapped by one useless arm, attempting to give nursing care. Upon recommendation from the physician and after considerable encouragement by the nurse and the social worker, Mr. D was admitted to the hospital for removal of the affected eye. Mrs. D was referred to physical medicine and has since had physiotherapy treatments. She has also visited the nutrition clinic for assistance with the family diet. These two are now able to be up and about the house, and with encouragement from the nurse are assuming the responsibility of caring for each other. With the assistance of a housekeeper and the help of many friends who visit them they are learning to manage for themselves.

The public health nurse is an important member of the Home Care team. Through

nursing services given to patients in the home and through participation in the clinical conferences she has been able to contribute considerably to the health and welfare of patients and families under supervision. In addition, she has contributed to the orientation of young medical students in the use of the facilities of community health and social agencies, and has demonstrated how the public health nurse functions in a community health program.

The public health nurse has found participation in this program a rich experience. It has furthered her understanding of how social and environmental factors may affect an illness, and how skillful handling of resulting problems can contribute to the general well-being of the patient and his family. Then, too, she greatly appreciates the close and consistent medical directions given her, and above all the opportunity of being a part of this program which has made possible an excellent quality of medical care to families in our community.

BIBLIOGRAPHY

Cherkasky, Martin. The Montefiore home care program. *American Journal of Public Health*, February 1949, v. 39.

Hilbert, Hortense. Extending hospital care to the home. PUBLIC HEALTH NURSING, July 1949, v. 41, p. 378-380.

Holmes, E. M., Jr., and Bowden, Paul W. Health department activities in the field of chronic diseases. *American Journal of Public Health*, July 1951, v. 41.

Insley, Virginia. Development of medical care programs to meet needs of individuals and families. *Selected Papers in Casework*. Raleigh, Health Publications Institute, Inc., 1951.

Richmond City Department of Public Health. Chronological review of the department of public health home medical care program. Unpublished.

Bureau of Medical Care, Richmond City Department of Public Health. Home care program, instructions for students. Unpublished.

Richmond City Department of Public Health. Home care program, Richmond, Virginia, November 1949-December 1950. Unpublished.

How One School Health Council Succeeded

BECAUSE IT was apparent that the nurse could not act in more than an advisory capacity the principal appointed representatives from the faculty of the school, the maintenance personnel, the top three grades, the local PTA as members of the council. Meetings were conducted informally and there was enthusiastic participation by the children. The first problem discussed was cleanliness. A contest between boys and girls to see who kept the bathrooms cleaner was conducted and the results were highly satisfactory.

Each month a different theme was stressed —teeth, good food for good health, sportsmanship, courtesy. Sportsmanship was a tough problem, however, and was continued for a second month. At the end of the school year, in May, there was a discussion of the whole program for the year, whether it had been of value and should be continued, if so, what the next program should include.

All the members of the council thought the program had been of value. The children decided it would be interesting to make a quick survey in each grade and ask the pupils what they thought about when they heard the name of the council. Personal cleanliness was most frequently mentioned in the replies, then courtesy. When these pupils were asked for suggestions for the next year no new topics were mentioned but they all wanted the council continued and wanted emphasis placed on the material already covered.

The council members were gratified by this expression of approval of their work. They thought that something should be planned in first aid in connection with the civil defense program of the Board of Education. The field of health was broadened to include mental health. The council found that contests, posters, compositions, surveys, and discussions in each room increased pupil participation and that health teaching could be incorporated in other subjects—for example, menu planning with an eye to cost of food items.

(Continued on page 272)

Pestalozzi Village

An experiment in international living

JANE BRUNNER McMACKIN, R.N.

THE INTERNATIONAL Federation of Children's Communities was founded in 1946. Today these communities may be found all over Europe. They are designed to give homeless children a homelike living free from institutional barrenness and rigidity. Sometimes they are subsidized by the government, more often supported by private donations. The institutions differ from each other in many ways, but they have this in common: the desire to give children, without home or family because of the war, a chance to grow up normally. One of the best of the communities is International Children's Village near Trogen, Switzerland.

When I first heard about Pestalozzi Village, as it is called, there were 132 orphans in the eight houses. These were boys and girls from six to fourteen years of age of seven nationalities—truly an international experiment. Children of the same nationality and religion live in family houses with three or four teachers for each group of fifteen or eighteen youngsters. Each house has its own schoolroom where lessons are given in the children's mother tongue and the textbooks correspond to the curriculum which may be found in their native country.

Out-of-school activities which bring all the children together play an important part in educating them in international understanding. The teachers share fully in this experience and are in complete harmony with their pupils and their colleagues. This is indeed essential although it is not always easy to achieve.

The house set aside for the children of one "family," its furnishings, its intimate atmosphere, the little "homeland" which it provides, the child's own domain, the family community, the close connection between home and school (which avoids the shock incident to "going to school") and, above all, the sense of being able to remain in the village without fear of being sent from one place to another—all these are factors the school uses in developing the children to their fullest capabilities.

Drawing and painting are among the favorite educational activities. Although the first spontaneous sketches done by the children on arrival show the part played in their conscious or unconscious lives by the scenes of horror later work depicts progressively calmer and more peaceful scenes as the psychological cure advances.

These communities had to face, in its most complex and serious forms, the typical situation of the child deprived of security and of his most cherished essential emotional ties. They were in position to analyze the effect of these disturbances on the child's development from the point of view of individual psychology as well as that of society in general. Through constant watchfulness the teachers, called upon to play the double role of parent and schoolmaster, discovered the basic needs in the children beneath their masks of indifference or rebellion and sometimes despair. To satisfy these needs, to balance and correct warped development, to dress and heal the wounds, a family circle

Mrs. McMackin is the author of Children and war which appeared in PUBLIC HEALTH NURSING, *December 1951.*

was organized and educational methods worked out in the spirit of the new education.

These children need love and happiness and must be freed from the burdens that weigh them down—from mourning, fear, shame, contempt, hatred, vengefulness, bitterness, vice, selfishness, disillusionment. They must be given confidence, a feeling of security, a sense of honor, self respect, and must develop consideration for others. The war is over, but their problem has scarcely changed. There is less concern with the problem of war-handicapped children per se today than there is with the physical, moral, spiritual future of a whole generation.

Gradually children learn to make use of freedom without restraint, and the more responsibility they are given in a trusting and homelike atmosphere, the more they become fond of ordered life and find natural outlets for their emotions. The children at the village lose their nightmares and the secret fears which sometimes resulted in violence or extreme reserve. They all are working together, making their contributions to joyful community life.

COURSES IN CARE OF POLIOMYELITIS PATIENTS

The following training centers have scheduled short courses in the treatment of poliomyelitis patients for nurses and physical therapists.

University or college and location	Date of course	
	Nurses	Physical therapists
Children's Medical Center Boston, Massachusetts Director, Dr. William T. Green Physical Therapy Department, Miss Shirley Cogland	One month starting July 7 and October 6. Longer individual courses can be arranged if desired.	One month starting July 7. Longer individual courses can be arranged if desired.
D. T. Watson School of Physiatrics Leetsdale, Pennsylvania Director, Dr. Jessie Wright	Three to six weeks. One course will be given in the spring. Others will be given later in the year if there are sufficient applications.	Three to six weeks. One course will be given in the spring. Others will be given later in the year if there are sufficient applications.
Georgia Warm Springs Foundation Warm Springs, Georgia Director, Dr. Robert L. Bennett		Three months beginning the first Monday in April, July, October. A limited number may stay six months if requested.
Institute of Physical Medicine and Rehabilitation New York University-Bellevue Medical Center New York City Director, Miss Edith Buchwald	Three weeks beginning May 12. Dates for fall courses not set.	Dates for fall courses not set.
Orthopaedic Hospital Los Angeles, California Director, Dr. Charles L. Lowman Director of Physical Therapy, Miss Susan Roen	May 19-23. October 20-24.	May 19-23. October 20-24.
University of Colorado Medical Center Denver, Colorado Director, Dr. Winona G. Campbell Instructor in Physical Therapy, Miss Dorothy Billenstien	Three weeks starting June 16 and July 3.	June 16-July 3.

For detailed information and enrollment write directly to the training centers. Nurses who need financial assistance to attend these polio courses should write to their local chapters of the National Foundation. Physical therapists who need financial aid to attend should write to the Division of Professional Education of the National Foundation at 120 Broadway, New York 5.

Reimbursement for Travel on Duty

HAZEL HIGBEE GIBBS, R.N.

THE VIRGINIA State Health Department has several plans of reimbursement for travel.

Plan 1. Employee ownership with base pay and upkeep. This plan applies to most employees of the State Health Department and is a very satisfactory one. The nurse furnishes her own car and is paid $20 per month for its use. In addition, ordinary repair service, gas, oil, tires, and batteries are furnished. These are secured through a state highway garage whenever possible. Courtesy cards are supplied for use when it is not practical to go to a highway garage. The employee pays her own insurance.

At the time the $20 monthly allowance was established it was estimated that this amount, over a two-year period, was sufficient, when added to the turn-in value, to meet the cost of a new car. Employees were expected to replace their cars approximately every two years and thus keep repair costs at a minimum. The principles involved in this plan seem sound, but the monthly allowance has remained stationary over the years, although the cost of cars has soared. It is understood that the monthly allowance will be increased to $25 July 1, 1952. Although not commensurate with today's operating costs it is as much as is permissible by law.

Plan 2. Employee ownership with mileage allowance. This plan applies only to employees working out of the central office in Richmond. The employee drives his own car and is paid 5 cents per mile with no additional allowance. This is grossly inadequate under presentday automobile costs. The rate of 5 cents per mile was written into the law, so change was difficult and slow. However, the law has just been revised to provide for an increase to 6 cents per mile, effective July 1, 1952.

Plan 3. State ownership. The State Health Department has an agreement with the State Highway Department whereby cars may be secured for official duty. Courtesy cards are furnished for securing gasoline and oil when it is not practical to go to a highway garage. Speedometer reading is recorded when the car is assigned and when it is returned. The Health Department reimburses the Highway Department on the basis of 4 cents per mile.

Collision and liability insurance is carried by the Highway Department. If the other person involved in an accident does not have insurance and is unable to pay it is possible that the employee driving the state car may be required to reimburse the Highway Department. To date we have had no such unhappy experience in which the Health Department has not come to the support of its employee.

Under plan 3, state-owned cars are available under the following conditions:

(1) Employees from the central office in Richmond may "requisition" a car for a day or a week. In theory this is a good plan, but the fact is that if many employees were to requisition cars there would not be a sufficient number available.

(2) If for any reason an employee's personal car is laid up for repairs for any length of time a state car may be secured on a temporary basis to cover the period of expected need. This provision for meeting a period of emergency is a real help to local health departments.

(3) New employees who do not have cars and are unable to purchase them immediately

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may have state cars assigned for a period of six months. This provision is a very real asset to the recruitment of nurses, for the majority of young graduates fall into this category. When it is expected that the nurse will be given an educational scholarship at the end of a year the assignment may be extended for a six-month period. When the nurse returns from school she is again eligible for a car for six months. By this time the nurse is expected to make plans to have her own car.

The six-month basis for assignment was agreed upon in order that the few cars available might serve as many persons as possible. A definite number of cars is not earmarked for the Health Department. However, most of the time we have an average of ten to twelve cars assigned to recently employed nurses. Occasionally the employment of a nurse has to be postponed because a car is not available. Advance planning, however, reduces these occasions to a minimum.

At the present time the matter of reimbursement for travel is being given considerable attention. Because of the legislation previously referred to it is not possible to increase reimbursement commensurate with operating costs. However, one suggestion under consideration is that employees in local departments be given the opportunity to elect the plan of their preference; that is, plan 1, or mileage at the rate of 6 cents as is provided for employees working out of Richmond. Whatever their choice is, it will hold for the fiscal year.

No further choice will be open to Central Office personnel other than the 6 cents a mile or use of a state car as set forth in plan 3, part 1.

I believe there is less dissatisfaction among personnel of the Virginia Health Department regarding reimbursement for travel than is found in many places. It can be said with real conviction that the ability to say to an applicant "If necessary, we can furnish you a car for six months" is a real boon to the recruitment of nurses.

Editor's note: The plans presented in this article will be of interest to agencies seeking solutions to transportation problems. The actual amounts of reimbursement are recognized as inadequate to meet costs. We think it is important, therefore, that this article be studied for the patterns of reimbursement described, but that in working out any scheme for reimbursement, actual costs be given more realistic consideration.

This is the fourth article in a series on cars for public health nurses. Be sure to review earlier articles in the February, March, and April issues.

School Health Council

(Continued from page 268)

One of the biggest problems encountered was getting material back to the rooms, so the council plans to have more faculty representation in meetings and may possibly have representatives from the three lower grades.

It is difficult to measure the value of the health council. A university administrator has said that the best way to evaluate the health attitude of pupils is by accumulation of teacher observation records rather than by construction of health attitude tests. This means more work for the teachers but they will cooperate when they see the value of such evaluation.

Here are excerpts from the report of a student in one of the council projects, cafeteria courtesy, which illustrate some good elements of health practices: Talk politely and clearly to the cafeteria manager and workers. Always take a tray. Yelling to others in cafeteria is not thoughtful. Move around only when necessary. Have good table manners. Gruesome subjects should not be discussed in the cafeteria. Keep lines orderly going in and out of the cafeteria. Keep your hands to yourself. Obey the monitor of your table. Try not to get your comic books on other children's trays.

Abstracted from a report from Dade County Health Unit (Florida) September 1951.

Parents' Classes: A Fertile Field for Mental Health Concepts

RITA CHISHOLM, R.N.

THE REPORT OF the International Congress on Mental Health states that education in mental health appears to be most successful if it reaches people at critical periods in their lives.[1] The period of expecting a baby, especially a first baby, is indeed such a critical period when there is a great readiness to learn. Expectant parents sense deeply the change that is coming in their family life, the new relationships that are being formed, and the delicate adjustments necessary to their new status. What an excellent opportunity a public health nurse has in teaching classes for expectant parents to improve the mental health of parents as well as to lay foundations for parent-child relationships that will have farreaching effects!

The immediate aim of parents' classes is to develop in both parents a sense of security during the antepartal period, a feeling of accomplishment during labor and delivery with a minimum of physical and emotional discomfort, and a readiness to care for the baby with confidence and real enjoyment. The ultimate aim is to create attitudes and viewpoints which will influence each family's living long after the baby has outgrown the pink and blue stage.

These aims require teaching scientific facts regarding anatomy and physiology which can help parents understand better what is happening during pregnancy, labor, and delivery; why certain rules of hygiene are necessary, and the basic principles of child care.

To do this successfully the public health nurse must be consciously aware of her own behavior and role in each situation. She must understand the feeling, attitudes, and behavior of the expectant parents attending the class, encouraging the release of their anxieties while being aware of the difficulty some have in doing so, especially in a group. She must also realize her opportunity and responsibility for helping to lay the foundation of good parent-child relationships.

The nurse teaching such classes must be a friendly, emotionally mature person, willing to give the necessary time and effort to form and use constructive relationships with the expectant parents. She should be aware of her own attitudes and behavior, and guard against them adversely influencing the reaction of the group. Her manner, her tone of voice, the very words she uses, are important. Much of the terminology of obstetrics, such as labor pains, forceps, lightening, et cetera, may have frightening connotations for her listeners. She must be accepting, comforting, know how little to say and how much not to say, and able to practice the art of listening. Her role is one of giving support and realistic reassurance, often as a comforting mother figure. As one mother expressed it, "It was so nice to feel that someone else had a sincere interest and understanding of our feeling in the tremendously important experiences in our lives —having our first baby."

To understand the feelings, attitudes, and behavior of the expectant parents the nurse must realize that with our present public school educational policies and family attitudes toward the subject of sex most adults have little sound knowledge of the anatomical and physiological functioning of reproduction and childbirth. Numerous misconceptions regarding pregnancy and the birth of a

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baby have been handed down from one generation to the next. In addition, modern fiction, movies, and the exaggerated tales of neighbors and families, as well as their traditional customs and attitudes, influence the reactions of expectant parents towards childbearing.

We know that lack of knowledge breeds fear and that expectant parents frequently have many. Fear of labor and delivery, of injury, of possible death of child or mother, doubt of their ability to be good parents, and many others may be present, often causing tensions and anxieties disastrous to the pleasure of anticipating and caring for the baby. How then is the pregnancy being accepted—with fear, resentment, resignation, rejection, or with eagerness and anticipation?

The public health nurse must realize that such feelings may not be easily verbalized but may be expressed in devious ways in behavior. How very important it is for the nurse to recognize these fears and anxieties in the behavior of the individual in the group and encourage expression of her feelings as well as an exchange of ideas, and to give her support and reassurance! During one parents' class the nurse noticed that a woman seemed very tense and uneasy. She managed to detain her and her husband after the class and found that after twelve years of marriage they were having their first baby at ages thirty-seven and thirty-eight. Mrs. D had had a successful career as a commercial artist. On her first visit to her doctor she was so tense he was unable to examine her. After attending the classes with her husband, discussing her distorted feelings regarding pregnancy and childbirth, and doing some reading under the direction of the nurse, her attitude changed to the extent that she was sufficiently relaxed to have a successful natural childbirth without the aid of sedatives and with little encouragement from her obstetrician and the hospital personnel.

In our organization in order to provide a setting designed to encourage release of tensions and anxieties the classes are small, averaging from six to eight couples, and are held at a convenient hour in the evening at the health center in the community. The chairs in the room are arranged in a semicircle, a circle, or around a table, with the public health nurse sitting within the group. Smoking is permitted and an informal social atmosphere is maintained. The leader points out common factors in the group, such as mothers expecting babies in the same month, going to the same doctor, living in the same community (parents come from several surrounding communities). Usually all are having first babies. Simple refreshments, which can be used as a teaching point, are served and some of the most interesting and enlightening discussions have been during refreshments. This is a time when the nurse can arrange to sit next to someone who may have seemed hesitant in participating in the discussion, thereby giving encouragement.

At the first meeting through group discussion, a tentative but flexible plan for the six meetings is made, using a broad topic for each. The material is presented in a friendly, helpful manner to promote discussion and to encourage following the constructive suggestions which are given. A healthy respect for heredity is encouraged, along with an appreciation of the dynamic concept of growth, to interest parents early in their roles. Factors influencing the fetus from the time of conception are talked about in relation to the physical and emotional wellbeing of the mother. If it is late in pregnancy the nurse is careful not to arouse guilt feelings. Pointing out the father's direct and indirect influences on the growth of the fetus and during labor and delivery helps him to identify his role.

The nurse must be willing to follow the lead of the participants when it seems to be significant in understanding behavior or encouraging release of anxieties. The film *Human Reproduction* is used as a springboard for discussion of anatomy and physiology of the reproductive system but often leads to discussion of sex education of children and the expression of many feelings. The nurse must be a patient listener, especially when an individual tells exaggerated stories of what happened to a friend of a friend. She should realize that he or she may be seeking reassurance and react accordingly.

Through careful observation and a sensitivity to unspoken reactions the nurse must be aware of the need to follow a clue further, because some individuals need more encouragement than others in the group. For example, one woman, when breast-feeding was being discussed, became flushed and restless but remained silent and seemed uncomfortable. This reaction was reported to the public health nurse in whose area Mrs. S lived. When the nurse visited the home, Mrs. S told her that her husband was insisting that she breast-feed the baby. However, Mrs. S did not wish to do so, fearing that her social life would be too curtailed, a factor which might interfere with their marital adjustment. The resulting conflict of Mrs. S, who was overly anxious to be a good mother, was very disturbing. The nurse sought the help of the mental health consultant in guiding these parents. During several conferences the mental health consultant helped the nurse understand the influencing factors in the situation, and she gained the necessary perspective to enable her to give support and guidance to these parents during a difficult period of adjustment to the baby.

In addition to experiences in their own pasts our rapidly changing culture has created in new parents uncertainties regarding their new responsibilities. These are intensified by the numerous articles in magazines, books, and newspapers regarding a succession of theories about feeding schedules, toilet training, disciplining, and the upbringing of children in general. Confusion and tensions develop, since parents so often do not trust their natural responses. The public health nurse can do much to relieve their anxieties and set the stage so that the infant may have the greatest chance of becoming a happy, comfortable, useful individual living in harmony with his fellowmen.

Through discussion the public health nurse teaches basic principles of good child care, not detailed procedures. By stressing the factors of individuality she helps parents understand that there is no list of specific rules. She avoids giving a unilateral kind of information: this is good; that is bad. She explains that the "repeated experiences of being hungry, receiving food, feeling relieved and comforted, are the primary sources of baby's assurance that the world is a dependable place."[2] Germs of confidence, trust, and personal security are part of the baby's original equipment, but must be protected, developed, and guided.[3] This can be done regardless of economic status, education, and social position. A child's affection for parents can live and flourish under discipline and will survive an outburst of temper. The most important essential of infant care, as Dr. Benjamin Spock says, is "a pair of truly loving parents, offering a well rounded, easy-going kind of love. Spoiling of children never comes from too much love and affection but from misapplied or 'lopsided affection.'"[4]

The nurse urges the parents to approach their new responsibilities with realization that basically children wish to be loved, to love, to cooperate and imitate, and do not need to be trained in the ways of righteousness.[5] They need opportunities to live and learn and can be "trusted to follow their inner laws of development, needing from parents chiefly love, encouragement, and guidance."[6]

BIBLIOGRAPHY

Bakwin, Harry. Psychologic implications of early child care. *The American Journal of Nursing*, January 1951, v. 51, p. 7-10.

Farnsworth, Dana L. The nurse's role in mental health. PUBLIC HEALTH NURSING, April 1951, v. 43, p. 173-177.

Gilbert, Ruth. Nurse's responsibility to her patient. PUBLIC HEALTH NURSING, November 1947, v. 39, p. 546-553.

REFERENCES

[1] Statement by International Preparatory Commission. International congress on mental health. 136 Gower Street, London, H. K. Lewis, 1948. p. 37.

[2] Robinson, Marion. What bends the twig? *The Survey*, January 1951, v. 87, p. 27.*

[3] Preston, George H. *The Substance of Mental Health*. New York, Rinehart, 1943. p. 139.

[4] Close, Kathryn. Youth in today's world: conference report. *The Survey*, January 1951, v. 87, p. 20.*

[5] Senn, Milton J. *Symposium on the Healthy Personality*. New York, Josiah Macy, Jr. Foundation, 1950. p. 198.

[6] Robinson, *loc. cit.*

* Special section of magazine on Midcentury White House Conference on Children and Youth. Many of the White House Conference papers appear in *Proceedings of Midcentury White House Conference on Children and Youth, Report of Conference Sessions.*

Introducing the Marine Tiger

JOSEFINA ORTIZ, R.N.

MARINE TIGER is a nickname given by fellow countrymen to Puerto Ricans who are recent arrivals in the United States. This nickname became popular during World War II when the army transport that bears that name brought Puerto Rican civilians in large numbers for work in the war manpower program. It has the same connotation as "greenhorn" or "jibaro," the latter being the term used to designate rural people who are newly arrived in the cities and towns in Puerto Rico. Although American citizens by birth Puerto Ricans are regarded as foreigners upon arrival in this country, even by members of their own native group.

Puerto Ricans leave their homeland for continental United States each year in large numbers. In 1950 there were 34,703 arrivals.* New York City receives the greatest influx, except during the summer months, when a large number go to work in farming areas. In June 1951, 15,000 came to work on farms. Not all of these people had been farmers in Puerto Rico. Many were recruited from small towns and cities and had little experience in farming.

The Puerto Ricans arriving here represent all classes of society. People of the well-to-do and middle classes usually come for pleasure, education, business, or medical care. They usually have well established businesses or positions awaiting them in the homeland. Many among the low income group also return to the island, but others become acclimatized and settle mainly in established Puerto Rican areas. Public health nurses are likely to meet more Puerto Ricans from the low income group. This group falls into the three social categories which may be found in any nationality group in any community. The first is composed of people with some school education, aiming at social improvement. The second consists of people with no schooling who want to make a better living in order to give their children a better education and to spare them insecurities and deprivations. The third consists of a few with a lower moral code and less ambition, who in many instances interfere with the satisfactory adjustment of their well meaning countrymen.

It is helpful in understanding the problems of adjustment which the new arrivals face to know a little of what they have left behind them. Words cannot describe the poetry and beauty of the island, the appeal of the language, the richness of the traditions, the complexity of the relationships, and the comfort of the climate. Each of these factors has influenced the Puerto Ricans' thinking and way of life and conditioned many of their reactions to future experiences.

In Puerto Rico the man's place is not in the home; it is at his work—in the sugarcane fields, in the factory, or driving a "publico." When he is not working he spends his time at the plaza, where other people gather. If he lives in the country he may enjoy the fresh air and the scorching sun or meet at the neighborhood store to listen to the news or perhaps have a few drinks of native rum. In the evening he may join his friends on the "batey" (front yard) if he lives in the country, or on a balcony if he lives in the city. No wonder Puerto Ricans like to stand on the corners of the streets and on stoops of buildings here.

Many men coming to the states hope to leave behind their sense of failure in not being able to support their families adequately be-

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* Employment and Migration Bureau, Puerto Rico Department of Labor, New York City.

cause of the long periods of unemployment. The farm laborer will never forget the sight of his breadwinning tool, the machete, hanging inactive for six months of the year and that because of this a child died from the lack of adequate food. The industrial laborer leaves behind similar disappointments, remembering when the grocer could not be paid and the means of subsistence depended on the number of "chiripas" (odd jobs) he could get. On the continent he will meet new insecurities and disappointments in his work, but these will not seem so great when compared with the old hardships of wages as low as two dollars a day.

The man gives up the traditional position of superiority in the family constellation, which is inherent in the Spanish culture, to share here a position of equality with his wife and children. Each man had a certain status in his community because of his dominant role in the family. In the United States he may lose his position as master of the house.

Women from the lower income group of the urban zones also have felt the impact of hard work and poverty. Many have memories of long working hours for small pay as hand laundresses, lottery ticket peddlers, maids, and the younger more skilled ones as workers in the needlework trades. The rural woman remembers how her children used to help her pick coffee beans and return late in the evening, often dripping and cold from the rain. These things she will never forget, nor will she forget that one child died from pneumonia; but she will never connect this with the many deprivations in the child's life.

The child leaves his friends and pets. He will remember breakfasting on a cup of black coffee and walking miles and miles to school if he was fortunate enough to be enrolled. The rural child helped his father on the farm, looking after the animals (if there were any) chopping wood, collecting twigs for fuel, or carrying home on his head huge tins or pails of water from distant wells or streams. In the cities children had more opportunity to continue schooling after graduation from junior high school or after completing the eighth grade. However, many of them had to give up school because expenses increased as they advanced. The Puerto Rican children have left behind a past full of limitations and insecurities. In the United States they will not be haunted by hunger as they knew it and they will find unlimited opportunities for education. There will be new demands and a greater need to conform to a routine, something which will be new to them, since life in the homeland was very simple. The Puerto Rican children coming to America may be faced with new types of illnesses, but they leave behind the more devastating ones such as diarrhea and parasitic conditions.

The entire family is leaving the common experiences of the homeland which provided outlets for group expression, social interchange, and recreation. Baptisms, weddings, wakes ("velorios") extended beyond the realm of the family into the community. They helped to strengthen familial ties and also to integrate and strengthen community relationships.

The pageantry which was another outlet for social expression will no longer be a major part of the newcomer's life. He will miss the familiar celebrations and festivities such as the patron saints' holidays, the Nativity, the carnival and its parades, and Lent with its religious processions. Family dances were popular. These required little preparation and little expense—often the orchestra consisted of two or three stringed instruments, a "maraca" and the native "guiro." At dancing clubs there were usually more elaborate preparations and a better orchestra. Accessibility to clubs was determined by lineage and prestige rather than by income or academic attainment.

There were other forms of recreation in the homeland of which the Puerto Ricans were fond. Cockfights and horse races, besides being sports, were legalized means of gambling. The insular lottery was another legalized means of gambling. Puerto Ricans are enthusiastic about baseball, and in the homeland they were fanatical about the home teams. Spanish movies from Mexico and South America were patronized to a great extent, and Puerto Ricans in some American communities may miss this source of recreation.

Puerto Ricans bring not only their customs and traditions but also an eagerness to work

and to excel. If they find work immediately they are likely to build for themselves a good reputation. A few Puerto Ricans may be less ambitious and less eager to work, perhaps for reasons of health or because they feel reasonably secure economically.

There are many among the Puerto Ricans who need intensive medical care. Many are handicapped in trying to do better work or find employment because of past illnesses or chronic ailments. The debilitating conditions most frequently found are tuberculosis, venereal diseases, malnutrition, and intestinal parasites. Repeated attacks of malaria and intestinal parasites result in anemia. Dr. Juan A. Pons, Commissioner of Health of Puerto Rico, in his report for the year 1946-1947, stated that malnutrition was a great problem on the island, contributing to loss of social power. At the time of his report 80 percent of the population suffered from malnutrition.

Puerto Rico has made great strides in public health but poor economics, overpopulation, land topography, and little philanthropy have not been favorable to this growth. Quoting Dr. Pons further, "Eighty to ninety percent of the population were medically indigent, and 80 percent of the medicine practiced was public medicine. Most of the public medicine practiced in municipalities was substandard medicine." There is a lack of adequate facilities and trained personnel. Voluntary organizations are limited in Puerto Rico both in scope and in number, and public assistance is inadequate to meet the needs of the underprivileged people in this overpopulated area.

The Puerto Ricans coming to America pass through a transitional period in which they must adjust to a series of circumstances. In congested areas such as New York City they may feel enclosed in a cagelike world where another language predominates and where their own is incorrectly spoken because of the fusion of English and Spanish.

The newcomer may need a great deal of help in budgeting and marketing, since the family's income, either from wages or from public assistance, is much higher here. The Puerto Ricans soon find that they have to pay high rentals, whereas in the homeland little or no rent was paid. Also, rent here is paid in advance, a fact for which they are quite unprepared. This may be the beginning of an accumulation of debts, as frequently they have to borrow money to meet their needs. Although food prices are lower here the process of acclimatization demands that more food and a wider variety be used in their dietary intake. The seasonal changes demand a different type of clothing and a wider variety than that to which they had been accustomed. The newly arrived Puerto Rican soon learns that he must house, feed, and clothe his family correctly, and he has to learn to distribute his money accordingly. The public health nurse has a great opportunity for teaching these new arrivals budgeting and marketing.

Puerto Ricans will miss their old food patterns. On the island breakfast may consist of a cup of milk with coffee drunk while standing, cereal eaten in the middle of the morning; or it may be a more elaborate affair, according to the income and the individual's occupation. Preparation of coffee, cereal, and bread is altogether different from what people are accustomed to in America, and these foods are richer in food values and in flavor.

Rice and beans call for an elaborate preparation. There is more to it that simply boiling or steaming. The rice is used in many appetizing forms and the beans are of many kinds. The "sofrito," a sauce prepared with certain foods and condiments, can be added to the beans when they are cooked. Meat, fish, and potatoes are also included in the diet.

The typical Puerto Rican diet is fairly adequate except for calcium and iron. Fruits are usually eaten between meals, and there is a variety all year round. It is necessary to increase the use of such foods as green vegetables and fresh milk and to use a wider variety of meats and cereals, especially whole grain. Puerto Ricans have to develop an understanding of the need for certain foods and of their values, as their requirements in this country may be different from those at home. For instance, the constant exposure to sunshine in Puerto Rico takes care of their need for vitamin D.

Meal preparation in the United States may be a tedious job to the Puerto Rican woman.

She must learn new ways of preparing foods. Broiling, baking, and braising may be methods totally unfamiliar to her, as the native cooking equipment often does not include ovens and other modern kitchen equipment. Nutrition demonstrations may prove helpful if introduced at the point of interest; success depends on the demands of members of families for new foods, previous exposure to American cookery, prevailing foods on the market, prices, and cooking equipment.

Climate and clothing are responsible for changes in the skin. During the first winter here the Puerto Rican finds it hard to wear woolen clothes. As his tan fades and the wool comes in contact with the skin some irritation may develop, resulting in an intense itching throughout the body. In some cases scratching causes skin infections to develop. This skin condition, resembling scabies, may be an allergic reaction to wool, a result of nutritional deficiency, or may be brought on by the steam heating system and the use of hot water.

Although there was overcrowding in the island there was not the usual congestion of overcrowded apartments in cities. Because of the scarcity of apartments Puerto Ricans tend to live together, thus bringing upon themselves the usual problems associated with overcrowding—inadequate sleeping arrangements and cooking and eating facilities—and therefore increasing the risk of illness. In New York City as many as ten persons have been found sharing a furnished room.

Garbage and refuse were no problem in Puerto Rico since there was so little for disposal and this was often thrown to the chickens, pigs, and goats in the yard. Some Puerto Ricans who arrive in this country may have to learn the use of certain sanitation facilities with which they may not be familiar.

Language seems to be the greatest handicap to Puerto Ricans coming to America. It is far easier for them to understand the orders of a foreman about crops in the fields or the mechanical pattern in the factory assembly work than to follow correctly extensive medical or nursing instructions. They can imitate patterns of work but they cannot easily understand and carry out suggestions for medical or nursing care. As public health nurses we must be far more understanding and sympathetic and should not be disappointed when we do not see quick results from our teaching.

In clinics difficulty arises through mispronunciation of the newcomers' Spanish names, which are Anglicized by personnel and not recognized by the Puerto Ricans. Also, difficulty arises when they are asked for information because they may not remember certain facts such as birth dates and menstrual dates. Celebration of birthdays and wedding anniversaries is not a typical Puerto Rican pattern.

The Puerto Ricans are potential prospects for a sound health education program. They are willing to accept new ideas and to face difficulties in exchange for health and other comforts. The many needs and deprivations of these families have motivated their eagerness for self improvement. The public health nurse in Puerto Rico helped to create this eagerness for health, although the extent of her teaching was influenced by her many clinical activities and the lack of available resources to meet special needs. The public health nurse in the United States has more opportunity to cover broader aspects of family health and more facilities for health improvement. Therefore, she is in a position to orient Puerto Ricans—the Marine Tigers—to healthful family and community living and to a happy adjustment in a new land.

Should Qualified Practical Nurses Be NLN Members?

ELLA M. THOMPSON, R.N.

This article has been prepared by the field consultant of the National Association for Practical Nurse Education at the request of the Joint Coordinating Committee on Structure of the Six National Nursing Organizations and presents the point of view of a professional nurse working closely with practical nurse schools.. Opinionnaires on this question have been sent to all constituent units by the national organizations participating in the plan to reorganize and this question also will be brought before all members attending the Biennial Convention in June before any recommendation is made.

AMERICANS are organizers. Our strength as a nation is partly traceable to getting together in groups to get things done. Business and industry have learned to consolidate and merge interests for a common purpose. Religious groups have found ways to worship together under one community roof. With the whole earth accessible in a few hours, the people in every continent have become neighbors of one another instead of geography and history book characters. So nothing could be more natural than that we should be concerned with the problems of the smaller parts of countries—the cities and towns and villages—and with the individuals and families in those communities who need nursing care. We have come to realize that these problems are similar—that combined efforts will find the answers sooner.

The need to combine and coordinate the national efforts in nursing became increasingly acute during World War II. The national organizations concerned with professional nursing began to see that there were gaps and overlapping in the work that they were carrying on for a common cause. Out of this perception an idea was born—to study these organizations to find better ways of accomplishing the colossal job in nursing. And out of this study came the plan for a new national organizational structure.

Purpose of the NLN

According to this plan there will be, in addition to the American Nurses' Association, a new organization, the National League for Nursing (NLN). Its purpose will be to plan for the development and improvement of nursing education and organized nursing services in communities so that the people may have the kind, quality, and quantity of nursing care they need. It will *not* be a professional nurse organization as will the American Nurses' Association. Instead, it will be an organization in which nurses will be able to sit down with members of allied professional groups and community representatives to plan for the development and improvement of both organized nursing education and organized nursing services.

NLN members will be of two types: individual and agency. Individual members will include professional nurses, members of allied professional groups, members of boards of directors associated with organized nursing services or nursing educational units, and other persons concerned with nursing. NLN agency members will include nursing services that are organized in hospitals, convalescent homes, and other institutions; nursing services in schools, industries, health departments, and other community agencies; visiting nurse associations; and schools and programs for

nursing education whether associated with hospitals, colleges, or universities.

The groups responsible for planning for the new organization have tried to find the answers to several vital questions: If NLN is to be concerned with helping to meet the nursing needs of the people in communities throughout the country, shouldn't it be concerned with practical as well as professional nursing? And if NLN is to be concerned with practical nursing shouldn't practical nurses be members? If professional nurses have the opportunity, through the NLN, to work with allied professional groups and community representatives in developing and improving professional nursing services and education shouldn't practical nurses have the same opportunity in regard to practical nursing?

Practical Nurses as Members of the Nursing Team

Recognition of the place of the practical nurse in nursing services has been evolutionary. It has grown out of a need for nursing care that has not been satisfied by professional nurses simply because there are not enough of them to go around. World War II speeded up the evolution of supplementary groups to take care of civilian patients when so many professional nurses were in the armed services. The Red Cross nurses aide and the trained practical nurse demonstrated how a worker well trained in simple nursing technics could safely supplement the nursing care given by professional nurses.

The nursing profession has wisely built on wartime experience in meeting today's demands for nursing personnel. We now know that nursing consists of a complexity of jobs requiring varying degrees of skill. We have found that the trained practical nurse can fit into the various nursing services offered to the community. Today it is recognized that the practical nurse is a member of the team that provides nursing care to the people. She is employed by visiting nurse associations and by hospitals, and she is especially needed to give care to people with prolonged illness when professional nursing care may not be available.

In Visiting Nurse Associations

A number of visiting nurse associations and other public health nursing services have trained practical nurses on their staffs. The NOPHN in 1951 studied a sampling of agencies and learned that thirty-nine of them were employing 149 practical nurses. Since this sampling was small undoubtedly more public health nursing services employ practical nurses.

Expansion of the employment of practical nurses by visiting nurse associations has been gradual and sound. In PUBLIC HEALTH NURSING, December 1950, Elisabeth C. Phillips tells the story of an agency which employed two graduate practical nurses, then added one at each six-month interval. Today the agency employs five graduate practical nurses. The policy of employing practical nurses in this agency had the full endorsement of the professional nurse staff and the board of directors before it went into effect. Patients are assigned to the practical nurse if they need a simple type of care. Supervision by the professional nurse is regular and discriminating, depending upon the needs of the patient and family and the experience of the individual practical nurse in the agency. The practical nurse is a recognized staff member. She has a careful orientation to the service, including some observation of what the public health nurse does so that she understands her role in relation to that of the public health nurse. Also, the public health nurses on the staff are oriented to the practical nurse's work and responsibility in the agency. Patients, physicians, and the professional nurse staff are well satisfied with the results.

In Hospitals

Many hospitals in the United States employ practical nurses. It is difficult to give an accurate number because of the various titles used to describe the nonprofessional worker. Many of these workers are not trained practical nurses as we think of them today. Instead, they are people who have been trained on the job to meet the needs of an individual hospital.

Some hospitals make an effort to employ only trained practical nurses. They recognize that the trained practical nurse has

demonstrated her ability to give safe nursing care to certain types of patients in hospitals. But the supply of trained practical nurses is limited because there are so few practical nursing schools ready to prepare the number of trained practical nurses that are needed.

Giving Care to Patients Who Have Prolonged Illness

Providing adequate nursing care for people who are confined to their homes with disabling and prolonged illnesses is a serious problem. The National Health Survey made by the United States Public Health Service during 1935 indicated that 23,000,000 persons had some chronic disease and that at least 1,500,000 persons were disabled for twelve months or longer. Since chronic illness is more prevalent among older people, and since they constitute a large part of the population the problem of providing adequate nursing care to persons at home with longtime illness is especially in need of solution. Providing them with care by private duty professional nurses is not the answer evidently because so many private duty professional nurses are needed and seem to prefer to work in hospitals. (Fewer than 2 percent of private duty professional nurses work in homes.) Part of the answer seems to lie in providing for persons who have prolonged illness at home the kind of care that trained practical nurses are prepared to give.

Practical Nursing in the NLN

The new National League for Nursing will be concerned with helping communities meet the people's needs for nursing. Therefore, the NLN logically and inevitably will be concerned with practical as well as professional nursing and with practical nursing service as well as with practical nursing education.

In the NLN professional nurses will have the opportunity to sit down with members of allied professional groups and community representatives and plan for the development and improvement of organized professional nursing services and education. It is only fair, if we believe in democracy, that practical nurses have the same opportunity in regard to practical nursing. Indeed, the matter is more than a question of democratic principles, for practical nurses would have a great deal to contribute to the NLN. They would be able to tell whether their education has prepared them to give good service and whether they are giving the service that patients need.

Everyone knows that honest participation in the affairs of any organization comes through membership. We, as members of an organization, feel responsible for finding the answers to its problems because they are our problems. We have a definite pride in those standards that we have helped to establish and, when it becomes necessary, are better able to interpret and uphold those standards. This would be true of trained practical nurses if they were members of the new NLN. Having a practical nurse membership in the NLN would also provide national recognition of the practical nurse's value as a member of the health team.

Practical nurses are showing by their work in their state and national organizations that they are responsible people—that they are eager for guidance and for the kind of preparation that will insure good nursing care for their patients. They are serving ably on the committees of other organizations—community and professional—and they are offering genuine cooperation in the job of providing nursing care.

Possible Practical Nurse Membership in the NLN

The proposed NLN bylaws, published in April 1952, do not provide for practical nurse membership. But if practical nurse membership were to be established in the National League for Nursing eligibility would be based on preparation. This is fair, since the eligibility of professional nurses for professional nurse membership in the NLN is also based on preparation. To qualify for practical nurse membership it has been suggested that a practical nurse be a graduate of a school approved by the National Association for Practical Nurse Education or by the appropriate state licensing body. Since there are only approximately 30,000 such graduates, the practical nurses eligible for NLN membership would not exceed this number. This would compare with more than 500,000 active

and inactive professional registered nurses who would be eligible. The ratio of eligibility would be one practical nurse to seventeen professional nurses.

If practical nurses seek membership in the NLN professional nurses should welcome them as coworkers. It would mean that practical nurses have a sense of responsibility and respect for their work; that they are asking for the opportunity to prove they can meet standards that will distinguish them from irresponsible people doing the same work. Professional nurses need have no fear for their security as long as they maintain their own standards, are aware of changing conditions, and continue to focus attention on nursing to meet community needs. The National League for Nursing will demonstrate constructive leadership by giving every group concerned an opportunity to contribute to plans to provide good organized nursing services and sound nursing education.

Some nurses sincerely believe we should be able to get enough professional nurses to give nursing care to everyone who needs it. The organizations that have been concentrating high-powered efforts on nurse recruitment tell us that there is not enough womanpower in the United States to supply the number of professional nurses we need. Times have changed since teaching and nursing were the only professions considered respectable for women. Today nursing must compete with many other fields to enlist the interest of a specifically qualified group.

Members of the organizations that are planning to reorganize will be asked at the 1952 Biennial Nursing Convention at Atlantic City in June to discuss the possibility of including graduates of approved schools of practical nursing as members of the new NLN. When that discussion takes place we hope that they will keep in mind the general purpose of the new organization and the facts presented in this article. The major concern must be to find the answer that will best meet the people's needs for nursing—that they have the kind, quality, and quantity of care they need.

Emotional Stress

(Continued from page 252)

changes in the situation such as shifts in routine and job assignments, and by any reminder which symbolizes for the individual the disaster experience.

Although it is true that people can work productively for eighteen to twenty-four hours at a stretch under the pressure of an acute emergency they do so at the risk of indefinitely postponing their recoil reactions and of precipitating a breakdown. Pressures of outside circumstances plus the urgency of team members to "keep on working" make it easy to push people beyond their biological limits of endurance unless definite policies have been established beforehand about hours of work and unless these policies are rigidly carried out.

Prophylaxis includes the prevention of physical exhaustion, encouragement and opportunity to talk about experiences, the provision of ample food and clothing, and the fostering of group solidarity and support. Sleep is valuable in building up defenses and sedation may be needed for those members of civil defense teams who are too "keyed up" to get adequate rest. The habitual use of sedation is, of course, to be avoided. People who find themselves requiring sedation every rest period can usually profit from discussing their feelings with a psychiatrist or another competent person.

Part 2 of this article, Implications for the Nurse, will appear in the June issue.

In Memoriam

"And God shall wipe away all tears from their eyes; and there shall be no more death, neither sorrow, nor crying, neither shall there be any more pain: For the former things are passed away."
—Revelation 21:4

Ada M. Carr, June 28, 1951, Baltimore, Maryland. Miss Carr was editor of PUBLIC HEALTH NURSING from 1923 to 1930. She was known for her wisdom, sensibility, judgment, delightful whimsicality, and ever-friendly response to all who came in touch with her. Miss Carr gave much of her life to nursing and left it a better field for all her efforts.

Harriet Chichester, February 12, 1952, White Plains, New York. Miss Chichester served for thirty years with the DNA of Northern Westchester County. Before she became the first paid visiting nurse of Westchester County she served as an Army nurse in the Spanish-American War.

Mrs. Rufus Cole, September 28, 1951. Charter member and board member of the DNA of Northern Westchester County.

Coralyn A. Davis, August 20, 1951, Chicago, Illinois. Miss Davis had been on the staff of the VNA of Chicago since 1921. She was a nurse physical therapist and her last position was as supervisor of orthopedic service. She was an instructor part-time at Northwestern University.

Myra P. Dority, August 30, 1951, Sedgwick, Maine.

Mrs. Ella Noyes Eaton, April 10, 1951, Arizona. Mrs. Eaton was chairman of the Public Health Nursing Section, Arizona SNA. At the time of her death she was superintendent of nurses for the Creighton School District.

Stella Farris, April 26, 1951, Atlanta, Georgia. Miss Farris had been industrial nurse for the General Shoe Corporation.

Celia M. Ferguson, April 2, 1951, Columbus, Ohio. Miss Ferguson had been supervisor of nurses for crippled children with the Ohio State Department of Public Welfare since 1947. Miss Ferguson, a nurse and physical therapist, had been a public health nurse in the Chicago area for nineteen years.

Mrs. Winifred Kemp Gabriel, August 20, 1951, Tucker, Georgia. Mrs. Gabriel had been with the Veterans Administration for twelve years and with the Free Community Service in Atlanta for ten years.

Dr. Charles J. Hatfield, August 25, 1951, Philadelphia, Pennsylvania. Dr. Hatfield was a founder of the National Tuberculosis Association and an internationally known leader in tuberculosis.

Mrs. Carmelita Calderwood Hearst, October 9, 1951, Cedar Falls, Iowa. Prior to her appointment as the first NLNE consultant in orthopedic nursing on the JONAS staff in 1941, Mrs. Hearst was orthopedic teaching supervisor at the Iowa University Hospital School of Nursing and the Denver Children's Hospital. After her retirement from nursing service Mrs. Hearst served as a member of the Joint Council on Orthopedic Nursing and the JONAS Advisory Committee.

W. K. Kellogg, October 6, 1951, Battle Creek, Michigan. Mr. Kellogg donated much of his fortune to establish the W. K. Kellogg Foundation in 1930, which has financed a vast child welfare, public health, and education program, and provided scholarship funds for the preparation of workers in these fields.

Mary Louise Kennedy, January 1952, Kansas City, Kansas. Miss Kennedy was active in health and nursing interests for twenty-five years. For five years she was director of the Don Bosco Community Center in Kansas City, Kansas.

Lt. Col. Rae D. Landy (Army Nurse Corps, retired) March 5, 1952, Cleveland, Ohio. Army nurse for twenty-seven years. Col. Landy was one of the first nurses sent to Palestine by Hadassah and her service laid the groundwork for Hadassah's current health and welfare program in Israel.

Mrs. Pettis Lee, August 1951, Orlando, Florida. At the time of her death Mrs. Lee was president of the Orlando VNA.

Dr. Joseph I. Linde, September 15, 1951. Dr. Linde was health officer in New Haven for sixteen years. "His devotion to duty, exceptional judgment, and broad knowledge of community health problems were outstanding."

Delia West Marble, June 1951. Miss Marble had been board member, first secretary, ex-president, and honorary president of the DNA of Northern Westchester County.

Ruth H. Parker, May 1951, Moscow, Idaho. Miss Parker was on the staff of Latah County Health Department.

Florence E. Porter, August 23, 1951, Bismarck, North Dakota. Miss Porter was a supervising nurse with the North Dakota State Health Department for several years.

Arline Shaw, February 29, 1952, Cohoes, New York. Miss Shaw had been school nurse teacher in Waterford, New York, since 1928. She served as chairman of the School Nurse Teacher Section of the New York State Nurses Association for several years and was also active in the New York State School Nurse Teacher Association.

Barry C. Smith, March 31, 1952, New York. Mr. Smith was general director of The Commonwealth Fund from 1921 until his retirement in 1947. Under his leadership the fund took special interest in promoting child health and guidance programs and rural public health.

Emijean Snedegar, December 22, 1951, near Tehran, Iran. At the time of her death Miss Snedegar was making an inspection tour of Embassy stations in Tehran, Cairo, Rome, Paris, and London as director of nursing in the State Department health program for foreign-service employees. Commissioned in the USPHS in 1945 Miss Snedegar was detailed to the UNRRA health mission in Greece. Before entering the USPHS Miss Snedegar was supervisor of nurses with the Henderson County (Kentucky) Health Department and had done public health work in Nicholas County and Louisville.

May Upton, November 2, 1951, Kentucky. A public health nurse for twenty-four years, Miss Upton began her career in Knott County in 1928 and was noted for her work among children at the Carr Creek Settlement School. Since 1930 she served as public health nurse in McCreary County.

Dr. George F. Zook, August 18, 1951, Arlington, Virginia. Dr. Zook was known for his outstanding service and contributions to the field of higher education in the United States. He had been president of the American Council on Education for sixteen years.

* * *

Polio Pledge

If Polio Comes to My Community

I Will Remember To

Let my children continue to play and be with their usual companions. They have already been exposed to whatever polio virus may be in that group and they may have developed immunity against it.

Teach my children to scrub their hands before putting food in their mouths. Polio virus may be carried into the body through the mouth.

See that my children never use anybody else's towels, washcloths, or dirty drinking glasses, dishes, and tableware. Polio virus could be carried from these things to other people.

Follow my doctor's advice about nose and throat operations, inoculations, or teeth extractions during polio season.

Be ever watchful for signs of polio: headache, fever, sore throat, upset stomach, tenderness and stiffness of the neck and back.

Call my doctor at once and in the meantime put to bed and away from others any member of the family showing such symptoms.

I Will Not

Allow my children to mingle with strangers, especially in crowds, or go into homes outside their own circle. There are three different viruses that cause polio. My children's group may be immune to one of these. Strangers may carry another polio virus to which they are not immune.

Let my children become fatigued or chilled. Overtired or chilled bodies are less able to fight off polio.

Take my children away from our community without good cause. Polio time is the time to stay at home and keep with everyday companions.

For more information about polio write to the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

The Staff Nurse As Senior Adviser

MARJORIE BELL, R.N.

ONE OF THE most active members in a program for students in a public health agency is the senior adviser. To her is entrusted, even more intimately than to the supervisor, the responsibility of guiding another individual in professional, emotional, social, and educational experiences during a developmental period.

The purposes of the program differ with the student levels. For example, the undergraduate student who comes for a one-day observation may be seeking a more meaningful knowledge of the family for application in her hospital work. The apprentice public health nurse is determining whether she will elect this field for a career, and seeks to gain insight into its scope. Whatever the objectives, the agency offers a unified team to carry them out. The team includes administration, consultation, supervision, and staff nursing with the staff nurse on the immediate "firing line" at all times.

To carry on such a program requires understanding effort, wholehearted interest, and a dynamic attitude on the part of the staff nurse who would function in this role, not to mention thorough proficiency in the philosophy and practice of public health nursing. A senior adviser who has experienced the satisfaction of participating in a well planned and well received program feels a rewarding sense of achievement for the investment.

Guiding a student is challenging and stimulating to the staff nurse. She must extend her own resources, plan for and assist with the development of the student, and find ways of helping the student to meet her own needs. Ideally, the nurse who is chosen to be a senior adviser should possess all the qualities of a top-flight staff nurse. She should be warm and friendly, mature in her emotions and interpersonal relationships, flexible, a willing teacher, a skillful organizer, proud of her profession, and well acquainted with the broad principles which underlie the social, community, and preventive aspects of nursing wherever it is practiced. In general terms, the richer and sounder the nurse's experience and preparation have been, the more productive she can make the student's experience. In practice not every senior adviser has reached these desirable heights, but the experience of serving as a senior adviser with the assistance of a competent supervisor can be a tremendous growth potential for a staff nurse at any time in her professional life.

To meet the student's individual needs effectively the agency must possess certain data about the applicant in advance of her arrival. This information should be shared with the senior adviser. It may include the results, or at least a summary of the results of psychometric tests, educational ratings, work experience, health data, previous evaluation, personal interests, and other pertinent facts, as well as the student's expressed objectives in undertaking the program. In a supervisor-senior adviser conference the record can be studied and interpreted and general plans set up for the student. Our agency's policy is to match as far as possible senior advisers and areas to the anticipated requirements of the student.

Preplanning should include training programs for senior advisers, particularly those who are about to have their first experience in student guidance. The senior advisers find the advance help particularly useful. In our agency such a program takes the form of sev-

Miss Bell is a staff nurse, Health Bureau, Department of Public Safety, Rochester, New York.

eral meetings handled with group dynamics methods. The staff nurses use problem-solving discussion to determine their functions. Under the guidance of the educational director the group of senior advisers and potential senior advisers is divided into working groups of six to eight persons. Members of these small groups choose their leaders by common consent and discuss different parts of the student program. A recorder takes notes and summarizes the discussion before the assembled group at the end of the session. In this democratic manner the nurses participate in analyzing the purposes of the program and working out plans for meeting them. Mimeographed copies of the decisions arrived at in the meetings are distributed to the nurses for future reference.

Through such meetings a general understanding of the senior adviser's role in the student program is brought about. At the same time the shared responsibility of all personnel having a part in the program is emphasized and a feeling of unity is developed, with everyone's interest directed toward a common goal.

NO MATTER how good an understanding of the mechanics and interrelationships is established in a group, the actual day-by-day handling of the students with all the intangible implications rests on the shoulders of the senior adviser. For example, her attitude, conscious and unconscious, toward the program is an important factor. Pride in their profession is an essential quality of all nurses but more so of senior advisers. How can she stimulate interest in something which she herself does not feel interest in? If the senior adviser does not possess sincerity, dependability, and kindness how can she inspire the confidence of those with whom she works? The ability to think broadly is another essential quality of a senior adviser. Without it she would be limited in her ability to evaluate persons and situations. Patience is a virtue which she must possess in abundance. The sum total of these qualities helps the senior adviser to give the student security.

Students, like other human beings, need inspiration. The senior adviser must devise ways to give guidance and encouragement. For example, the quality of public health nursing performance which the senior adviser demonstrates may be emulated by the student. The senior adviser should have a clear understanding, however, that the identification implied in emulation is less desirable than the student's individual achievements. She should strive to help the student discover, recognize, and develop her own potentialities. Thus, while her performance will be in accord with accepted principles and policies, the student will grow and develop as a person and as a nurse. Then, hopefully having integrated the experience, the student will be able to use the new knowledge and skills in other situations when the senior adviser is no longer at hand to guide her.

Supervisory participation in this program is very important. The supervisor should be fully available to the student as well as the staff nurse. In many instances she is the sounding board for many of the ideas and plans of the staff nurse.

The senior adviser plans for the student through a process of discussion, demonstration, student practice, and more discussion. In the beginning most of the planning is done by the senior adviser, but she encourages the student to accept increasing responsibility in the planning of her own work. The senior adviser must keep in mind her goal: to prepare the student to be independent and to try her wings as soon as possible.

The point at which she can assume independence varies with the student. She is usually young in experience and therefore is dependent on the senior adviser. Overprotectiveness is a pitfall the senior adviser should be aware of. She must be careful that this dependency does not become too pleasurable to her and to the student. "Going out alone" is a momentous and frightening occasion for the student no matter how carefully and gradually the senior nurse has worked to prepare her. The student is eager, fearful, and shaky all at the same time. At this point a great deal of understanding, patience, and firmness is required of the senior adviser. She feels like a mother bird encouraging her young to leave the nest. Her reward is the shining

enthusiasm and pleasure exhibited by the student at her accomplishment.

The student must be given freedom of expression and the opportunity to apply what she has learned. How else can she become effective when working alone? When the senior adviser is tempted to monopolize a teaching situation she should remember that students learn by doing and through repeated practice.

As the student progresses in the program the senior adviser adapts her guidance to meet the changing needs. For example, later in the program the student is encouraged to attempt self evaluation. This can be done with the senior adviser's assistance in a daily conference at the close of each day. Home visits can be analyzed to discover if the student has correctly identified the problems and made suitable plans about them. This brings into use her knowledge of community resources, services of various social agencies, and the importance of interagency referral. The student can also analyze the degree of rapport between her and the families visited, realizing that this is the key to effective teaching. She may also look at her day's activities to judge whether she has made appropriate use of her scientific knowledge. The student should be increasingly able to function more effectively and on a more mature level.

One outcome of a student program is a constantly sharpened interest among the personnel of the agency. The general level of performance is raised by participation in teaching situations. If "the best way to learn is to teach" then each has a chance to grow. The agency is critically viewed by educators who are aware of performance and alert to the agency's effectiveness in the program. Such questioning is a challenge to all the staff of an agency to contribute their best to the program. In addition, many are spurred on to further education on their own initiative.

Such a program develops teamwork within the agency. The senior advisers and the supervisory staff develop a togetherness because of the close participation necessitated by a student program. The give and take of this relationship carries over to the service program with the expected beneficial results.

THE STUDENT around whom the program revolves reaps many clearcut benefits also. She learns ways of adapting hospital nursing technics to the home. She develops skill in making patient and agency contacts. She grows in appreciation of the patient as an individual, a member of a family and of the community. She becomes aware of the value of offering health supervision on a family basis in preference to trying to teach isolated individuals. She understands community resources better when she learns how they are used functionally in the care of individuals and families. She begins to recognize the importance of a community plan for health work.

Indirectly the community also benefits by this type of program through a more effective health service. Everyone benefits because everyone participates, to paraphrase a community chest slogan.

The Rochester Health Bureau public health nursing service has maintained a student program since September 1944. As various needs for public health nursing experience have arisen, programs have been planned to meet them. Today, this agency has educational programs for four different groups. They are carried out by a staff of sixty-six public health nurses and six supervisors, and the consultation services of a medical social worker, a health educator, a physical therapist, and a nutritionist.

One of the programs is designed to provide a one-day period of observation for students from the local schools of nursing. This is given as part of the emphasis throughout the student's nursing education on the social and community aspects of nursing. Most of the schools in Rochester participate in this program.

Another program is for graduate nurses majoring in public health nursing in a university program and still another is for graduate nurses in the apprentice program of the New York State Department of Health.

Nurses from the University of Rochester and from Syracuse University are accepted at this time. They are given five to twelve weeks of field instruction depending upon the individual student's need. Because of the many different backgrounds of this group, pro-

gram planning is of necessity done on an individual basis.

The apprentice program consists of an eight-month experience. These students are graduate nurses recruited by the New York State Department of Health in an effort to meet increasing demands for public health nurses throughout the state. The field practice is sufficiently long to enable the nurse to judge whether she wishes to continue in this field of nursing and to enable the agency to judge whether she is suited to public health nursing. If she does not remain this background should help her to function more effectively in any elected area of nursing.

A fourth program provides eight weeks field instruction for collegiate basic student nurses. At present Syracuse University is the only school sending students under this plan.

The agency is always trying to adapt the program to the student's unique requirements and to a considerable extent this effort has been successful. One method used to accomplish this end is that of conducting classes on a conference basis, replacing the lecture method in general. In this way, it is possible to build on the student's interests and knowledge and to provide more realistic motivations. Enough conferences are held to orient the student to various areas and to enable her to accomplish the transition from institutional nursing.

Conferences between the senior adviser and her supervisor are spaced according to the senior adviser's need. At intervals she confers with her supervisor to clear up stumbling blocks and to discuss progress and future plans. The supervisor and senior adviser in combination with the student also meet at intervals to evaluate the student's progress and development. Through this method the student learns to recognize her strengths and weaknesses and is guided to build wisely as she goes along.

In order to meet the evolving concepts of nursing education with its increased emphasis on family and community living, the student program at the Rochester Health Bureau is in a constant process of evaluation and revision. Inservice education and senior adviser preparation keep the staff attuned to these changes.

It is hard work being a senior adviser, but it is truly a creative task. The pleasure of guiding and stimulating a student to grow professionally, emotionally, and socially is a deep and satisfying reward. There is another reward for the senior adviser: she grows with her student.

BIBLIOGRAPHY

Jarc, Sophia A. Experiment in apprentice training. PUBLIC HEALTH NURSING, February 1948, v. 40, p. 96.

Smith, M. Ruth, and Davis, Kathleen M. Student advisers. *American Journal of Nursing*, November 1950, v. 50, p. 748.

Sparmacher, Dollie L. Student-centered teaching. *American Journal of Nursing*, December 1950, v. 50, p. 787.

Walsh, Patricia. Preparing for students. PUBLIC HEALTH NURSING, March 1947, v. 39, p. 136.

American Journal of Nursing for May

ABSTRACTS . . .

HOW LONG DO PATIENTS STAY IN GENERAL HOSPITALS?

One of the major developments in hospital care in recent years is a decline in the length of stay of patients in general hospitals. Chiefly responsible for this decline are medical advances (such as the antibiotic drugs) early ambulation after surgery and childbirth, and the prophylactic use of blood. The high birth rate in recent years with the resulting increase in demand for obstetrical beds has made for much earlier discharge of maternity patients.

For the United States as a whole the average length of stay in general hospitals declined from 12.9 days in 1940 to 10.0 days in 1950, or 22 percent. For New York City the average length of patient stay in general hospitals declined from 13.2 days in 1940 to 11.8 days in 1950, or 11 percent. Comparison of data in the above groups reveals that the average length of patient stay in general hospitals is higher in New York City than in the nation as a whole, that the rate of decline in the average length of patient stay has been slower in New York City general hospitals, and that the largest difference between the two groups is seen in the municipal general hospitals, where those of New York City actually show an increase in the average length of patient stay in more recent years.

Part of the difference between the experiences of general hospitals in New York City and in the United States as a whole is accounted for by the high rate of occupancy in the municipal hospitals in the city and the large number of patients with longterm illnesses accommodated by them. Also, the rate of admissions to general hospitals in the United States as a whole was much higher than the rate in New York City hospitals between 1940 and 1950, and a higher rate of admissions is usually associated with a reduction in length of stay. Another important factor is that New York City is considerably closer to meeting its total needs for general hospital beds than is the rest of the country and there is less need to accelerate discharges for the purpose of increasing the number of available hospital beds.

Type of control of hospitals—voluntary, governmental or municipal, proprietary—affects the length of stay and also the rate of decline in the length of stay, since the different types of hospitals tend to care for different groups of patients. The average length of patient stay is longest in the municipal general hospitals, shortest in the proprietary general hospitals, and intermediate in the voluntary general hospitals. Municipal hospitals are intended to serve the indigent and the medically indigent—the sick poor—and care for a larger than average percentage of patients with longterm illnesses, thus increasing the average length of stay. Proprietary general hospitals serve patients who pay for their care. A high proportion of service rendered by proprietary hospitals is to maternity patients, which serves to shorten the average length of stay in these institutions. Voluntary hospitals offer private, semiprivate, and private accommodations, and figures show that length of stay in the voluntary hospitals is longest on the ward, shortest on the semiprivate service, and intermediate on the private service.

Abstracted from the Bulletin of the Hospital Council of Greater New York, November 1951.

CASEFINDING THROUGH EDUCATION

Nursing service in the venereal disease program includes nursing care in hospital situations; assistance with patient care in various clinic services, including interviewing; home visits to selected patients and contacts; con-

ferences with physicians in private practice and allied agencies whenever these relate to the families for which the nurse is responsible. It is becoming increasingly clear that the varied experiences and needs of individuals and families in these situations make it impossible to influence the behavior pattern of the individual infected with a venereal disease unless the educatory experience is pitched at a level which helps the individual not only understand what to do and when to do it but also motivates him to take the next step—do something about it.

The study from which the following abstract was made describes some of the problems in achieving the goal of venereal disease education which leads to early casefinding.

The aims of this study were to attempt to describe some of the problems of the study of venereal disease education, to outline a broad program of research into these problems, and to present the results of a preliminary study following this research plan. In an attempt to understand the behavior of infected persons so that casefinding goals might be achieved, data from 1,098 questionnaires were analyzed to determine the difference between volunteers and nonvolunteers with primary or secondary syphilis.

Generally speaking, those persons who tended to volunteer for diagnosis and to volunteer more quickly were males, persons noticing symptoms, persons having had some previous venereal disease treatment, whites, persons with primary syphilis as contrasted with secondary, veterans, married persons, and persons twenty-three or more years of age.

In analyzing the data collected several things were learned regarding educational media. It is necessary for educational material not only to mention the various symptoms and explain that they may disappear but also to give emphasis to the need for early diagnosis. The fact that 4 percent of the nonvolunteers said they did not go for diagnosis, even though they had symptoms, because they had had a negative result on a previous blood test indicated the possible extent to which the routine or screen testing approach to casefinding, unless properly handled by giving complete explanation and interpretation of results, may be detrimental to the control program. Persons who are concerned about the possible tragic outcome of untreated syphilis are apt to volunteer and to volunteer quickly. Educational material should mention the dangers of untreated syphilis, and, at the same time, explain that prompt diagnosis and adequate treatment of early syphilis will prevent the serious consequences of late syphilis.

Since 11 percent of the volunteers and 9 percent of the nonvolunteers stated that they were afraid of passing their syphilis to a child or some other family member more emphasis should be placed on social responsibility. More emphasis should be placed on informing the public of the availability of clinics and their locations. High on the list of communications mediums which were apparently associated with volunteering are those which may tend to have personal impact, such as slides, pictures, movies, talk with friends and relatives, and talk with doctors or nurses. There is evidence that it is important to keep venereal disease information constantly before the public and to maintain a sufficiently high level of knowledge so that the apparently large amount of interchange of information by word of mouth is correct.

Abstracted from Syphilis Case Finding through Education by Morse, John W., and Iskrant, Albert P., in *Journal of Venereal Disease Information*, June 1951.

WHY CHILDREN CHEAT

Children cheat because they are taught to cheat. They are taught in and out of school by their parents, families, neighbors, schoolmates, and teachers. Before they enter school they have observed the ways adults cheat each other. Adults set bad examples by cheating the grocer, the postmaster, or the tax collector and thus indirectly condone the practice of cheating at school.

If they have not already learned to cheat from home experience children learn quickly after they have entered school. The teachers themselves contribute to the continuance and spread of cheating in a number of ways—by taking it for granted as a necessary evil and

doing little about it, by letting it continue even though they view the practice with alarm, by looking upon cheating as a matter entirely between themselves and the child concerned without regard to the other pupils in the class, by making an example of the cheater with such stern measures that his fellow students rate him as a martyr.

Children have a great deal of influence on their fellow students. By belittling schoolwork, speaking contemptuously of the "grind," or boasting of their own success in cheating they encourage others to take up the practice. Students who do poor work but get good marks dishonestly are likewise a subversive element, sometimes tempting good students to cheat as a form of self protection.

Cheating, like any dishonest act, is the result of a frustrated desire. A child may want praise, recognition, eligibility for a team, admission to college, or something else associated with good marks, and if for some reason he cannot attain those objectives he may resort to cheating. Parents who put constant pressure on their children to get better grades than they are normally capable of may be responsible for making their children resort to shortcuts and irregular practices. Some parents cooperate in forms of cheating to help their children show up well at school.

Impersonal factors in the school program may also be responsible for the spread and continuance of cheating. The curriculum itself may be a cause of cheating if it is lacking in interest and vitality. When motivation is low dishonesty is high, but when the curriculum is made interesting the students are more eager to work and have less incentive to cheat. The life adjustment education approach advocated by the United States Office of Education can solve much of the cheating problem because it stresses a curriculum directly related to life needs. Overemphasis on marks, too, causes much unnecessary cheating.

Honor systems in which pupils are trusted completely are doomed to failure since they take for granted the existence of the very self control and maturity that the school has a mission to develop, and when tests and surveys have shown that two thirds of all adults fail on typical honesty tests it is idle to dream of children in school taking tests and grading their own papers honestly without any kind of supervision.

From Why Children Cheat by Crawford, C. C., *National Parent-Teacher*, January 1952.

BALDNESS, DANDRUFF, AND GRAYING

Twentieth century man is not original in his concern with disorders of the hair and scalp. Way back in the sixteenth century B. C. Egyptian medical writings mentioned the problems of gray hair and baldness; and in the third century B. C. Aristotle made keen fundamental observations concerning baldness. Today conditions of the hair and scalp are still important problems.

The most common hair and scalp troubles—dandruff, balding, and graying—affect millions of people. These sufferers are bombarded with every imaginable sort of advertising, including exaggerated and fraudulent claims. They turn to quacks and magic nostrums, to beauticians and barbers, and to physicians (the dermatologist in particular) to rid them of their hair and scalp troubles.

Ordinary male baldness, marked by a gradually receding hairline and a balding patch on the crown of the head, is attributed to many causes but depends primarily on three factors—heredity, aging, and the effects of male sex hormones. About the first two factors medical science can do nothing, and to attempt to do anything about the third appears highly undesirable, since it might bring about other bodily changes, such as those of a feminizing nature, sterility, impotence, and other characteristics of eunuchoidism. It might make sense to look on ordinary male baldness not as a disease but as an evolutionary development.

Thinning of the hair on the scalp is far less common in women than in men. Excessive loss of hair in women comes primarily during the change of life and in the later months of pregnancy which emphasizes the influence of sex hormones on hair growth. The usual pattern of hair loss in women differs from that in men. In women diffuse thinning of the hair usually involves the entire scalp, not definite areas.

A type of hair loss which causes much concern and worry is alopecia areata which means "baldness occurring in patches." It comes suddenly and leaves shiny round completely bald patches which can vary from pea-sized areas to the entire scalp or the entire body. The disease is found in both sexes and at almost all ages. There is no one known cause for alopecia areata and often even the most careful medical checkup fails to reveal any cause whatsoever. Mental shocks or accidents seem the likeliest of all the suspected causes. In most cases the hair grows back completely.

Numerous other diseases may cause somewhat similar types of patchy baldness of the scalp. They may be the more serious and progressive or contagious diseases including certain forms of ringworm and syphilis.

Another disorder of the scalp is dandruff, resulting from some form of an active scaly process on the scalp. Varying degrees of itching and occasionally loss of hair may accompany the visible and troublesome scaling. Dandruff may follow abnormal secretions of the sweat and oil glands of the scalp, abnormal production of the horny layer of the skin, and perhaps also an accompanying excessive growth of certain microorganisms and the accumulation of particles of dust and dirt.

The following rules are helpful in keeping the hair and scalp free from dandruff and in good condition: (1) Brush the hair for ten minutes each day—this is perhaps the best form of massage. (2) Use a comb with smooth, rounded teeth, in order not to injure the scalp. (3) Shampoo regularly and thoroughly—once a week is sufficient for the average hair and scalp, but frequency depends upon the general condition of the hair and scalp—dry or oily. (4) If a hair dressing is needed use one that is not too drying or too oily or greasy.

Other diseases, such as psoriasis and ringworm or fungus infection of the scalp, will cause scurfiness and scaling that resembles ordinary dandruff. All forms of ringworm of the scalp must have immediate and proper attention to stop the spread of the lesions and to prevent infection of others.

Another common hair problem is graying, occurring eventually in most people and usually not too disturbing to the peace of mind. Gray or white hair is best accepted with resignation, since nothing can be done for it except the external application of tints, rinses, pencils, and dyes. The hair may lose its natural pigment and become white or gray at any age in either sex. In addition to the hereditary tendency toward graying many other factors have been considered contributing causes. Among them are severe illness, chronic disease, a sudden shocking experience, worry, vitamin deficiencies, and bleaching. Despite all theories it is still not known why the pigment that normally gives color to the hair shaft ceases to form.

Abstracted from Baldness, Dandruff and Graying by Sulzberger, Marion B., M.D., and Witten, Victor H., M.D., in *Today's Health*, September 1951.

SYPHILIS CASEFINDING THROUGH AN UNDERSTANDING OF KNOWN SYPHILITIC PATIENTS

The reduction of venereal disease is one of the major triumphs of public health in recent years. With the significant decrease in rates of infection considerable thought has been given to exploring all factors which may have bearing on the reduction of these diseases so that machinery can be developed to reduce the incidence further. In the field of epidemiology intensive study is being carried on to develop new skills and refine present procedures in casefinding. The following abstract from such a study will be of interest to nurses in that it provides data concerning the attitudes of persons who have a venereal infection and their willingness to seek medical supervision.

This study, conducted among patients in the treatment centers of Mississippi, was designed to learn more about the reasons why some people delay or avoid altogether the diagnosis of symptoms of early syphilis and how volunteers and nonvolunteers differed. Data were collected from 500 men and women with primary and secondary syphilis on a host of topics, including the nature and duration of their symptoms, their knowledge about

(Continued on page 306)

NEW BOOKS
And Other Publications

COMMUNITY ORGANIZATION AND AGENCY RESPONSIBILITY

Ray E. Johns, Ph.D., and David F. DeMarche, Ph.D. New York, Association Press. 1951. 274 p. $3.75.

This book is dedicated to the sound principle that community organization for health and welfare is "everybody's business." In other words, citizen leaders and staff members of operating agencies and departments of government have a responsible role to play in community organization. The position is taken that this is not a social welfare activity that can be handed over to and carried out by any one type of organization or section of the profession although the important role of community welfare councils and other bodies devoted entirely to joint planning and coordinating is clearly recognized.

It is apparent that the authors had the lay and professional leadership of operating agencies in mind as the principal audience even though there is much to interest and inform the community organization specialist. More than two thirds of the volume is devoted to a comprehensive—although not too intensive—survey of the whole cooperative movement in social welfare. Near the end the chapters, "Attitudes, Insights, Skills and Training of the Community Organization Worker" and "Some Guiding Principles," are particularly significant from the standpoint of the community organization specialist.

The volume is easy to read. It is not too technical and will not dismay the volunteer citizen reader, yet is definitely adequate as a student text. It should be especially helpful in giving a general picture and a point of view to prospective professional workers who will make their careers in operating agency jobs. Frequent summaries and use of outlines give the book life and meaning for those who want to "go over once lightly" as well as for those who wish to dig deep.

The fact that the authors are experienced and capable in both agency operation and community organization (although the very separation of these terms is contrary to the main theme of the book) is as obvious as it is true. They write from long and successful practical experience.

Several chapters at the end of the book are devoted to reporting on a questionnaire study of local interagency relationships made by the authors specifically in preparation for this work. Here they deviate from the pattern of sifting records and writings and painstaking reporting of events and background to plow relatively untilled soil. It is timely that agencies give attention to their "cooperative" relationships to the end that they be meaningful and productive and not just a matter of going through the proper motions.

In this day and age when complexity and specialization make cooperative community planning an absolute essential it is valuable to have the issues pointed up and some of the solutions suggested as they are in this book. It is worthy of the attention of all lay and professional workers in the health and welfare field.

—LYMAN S. FORD, *Associate Executive Director, Community Chests and Councils of America.*

ROSENAU PREVENTIVE MEDICINE AND HYGIENE

Kenneth F. Maxcy, M.D., Dr. P.H. New York, Appleton-Century-Crofts, Inc. 7th edition. 1951. 1,462 p. $14.

It is but rarely that one has an opportunity to review a book like this. Dr. Maxcy, a well known and stimulating professor of epidemiology at The Johns Hopkins University, has

drawn upon the resources of twenty-six contributing authors in creating for us the seventh edition of "Rosenau."

The first edition was published in 1913 and the sixth revision appeared in 1935. It takes but little reflection to appreciate that the ensuing years have seen a tremendous growth in knowledge about diseases, control methods, the maintenance of health, and the control of environment, as well as a growing awareness of the responsibilities of and the opportunities available to communities through appropriate public health facilities and services.

The book has kept tempo in a creditable manner with the deletion or curtailment of material which no longer presents an appreciable problem and, more important perhaps, through the addition of completely new subjects. Of particular interest to nurses are the new chapters—Infant and Preschool Services, Services for the Physically Handicapped Child, Senescence, Chronic Disease and Disability in Adults, Noise, Work and Fatigue, and Epidemiology. The latter chapter should be read by all who would understand the progress and recession of disease. The last section of the book, Public Health Organization and Activities, has several new chapters which afford rapid orientation on the general scope of activity, organizational structures, and variations at local, state, and national levels. There is also a new and very brief chapter on the voluntary organizations.

It is not only the new chapters, however, which merit attention. Many others are so completely rewritten that save for the subject heading they too are new. It is hazardous to single out portions of such a book, but in addition to those previously mentioned most public health and industrial nurses would find the sections, The General Health of the Working Population and The Promotion and Regulation of Industrial Medicine and Hygiene, helpful.

The book has remarkably good organization with a pulling together of all pertinent material into such section headings as Prevention of Communicable Diseases, Nutrition and Deficiency Diseases, and Maintenance of Health and Prevention of Disability.

The book is in no sense one that will be read by many from cover to cover. It is, however, a book which many will cherish as a quick reference text that will answer most problems satisfactorily and afford a carefully selected bibliography for more advanced reading.

—HARALD M. GRANING, M.D., *Regional Medical Director,* USPHS.

REHABILITATION NURSING

Alice B. Morrissey, R.N., B.S. New York, G. P. Putnam's Sons. 1951. 299 p. $5.

The author states that the purpose of *Rehabilitation Nursing* is to provide some means of accomplishing four basic objectives if nurses are to make a real contribution toward rehabilitating the handicapped. She lists these objectives:

(1) To acquire knowledge of the content of nursing care in rehabilitation (2) to develop an ability to teach the principles of rehabilitation nursing care (3) to extend the practice of rehabilitation nursing into every area of nursing care (4) to educate the public to accept the concept of rehabilitation.

As a reference this book is highly recommended to all nurses. Miss Morrissey has had excellent advisers and her additional reading lists are pertinent. Chapters five through eight list good orthopedic nursing technics and procedures applicable to all chronic or temporarily disabling conditions. Detailed descriptions of procedures for bladder and bowel rehabilitation and the prevention and care of decubitus ulcers are given.

Miss Morrissey emphasizes that the nurse is only one member of the rehabilitation team and the chapters on crutch walking and braces and those describing activities of the patient out of bed provide "only a few points and some hints." Therefore, for the patient's safety and to avoid misleading both the patient and his doctor the nurse must remember her limitations. No nurse should prescribe definitive exercises for a specific condition or presume to suggest which crutch gait a patient should use.

This book will give the nurse a review of

some good orthopedic nursing procedures. She will become more aware of what can be taught to the handicapped and, it is hoped, understand why it is worth while to let a patient perform activities himself despite the extra time the procedures consume.

—HELEN M. LAHEY, R.N., P.T., *Physical Therapist for Homebound, May T. Morrison Center for Rehabilitation, San Francisco.*

THE UNITED STATES PUBLIC HEALTH SERVICE, 1798-1950

Ralph Chester Williams, M.D. Bethesda 14, Maryland, The Commissioned Officers Association of the United States Public Health Service, Inc. 1951. 890 p. $7.50.

Within a few months of each other two important volumes have appeared which deal with the history of medical and public health activity in the United States. One of these, *The Story of the Rockefeller Foundation*, covers a great deal of ground tilled by a private organization and the other, the subject of this review, rehearses the great accomplishments over a century and a half of a great public institution, the United States Public Health Service. In the two volumes one can discern perhaps the strength of American practices through the dual channels of private money and the public tax dollar—a strength of dual coverage quite unfamiliar in any other country of the world.

The Public Health Service volume of almost 900 pages is an astonishing collection of "firsts" in medical and public health research and practice. Although it is not an easy book to read even the layman would find fascination in the detailed rehearsal of the accomplishments of the USPHS. The professional may look to it as a permanent sourcebook of authenticated material on personalities, procedures, and battles in the long, exciting, and continuing conquest of disease and of death.

The book moves from the origin and background of hospitals through the problems of quarantine, the evolution of public health, the extensive accomplishments of laboratory research, the field studies and demonstrations, on to intragovernmental and international health relations.

One unusual feature of the volume, and one rarely presented in most historical summaries, is the large amount of space devoted to the personalities responsible for so much of the work. More than eighty pages are used to revive the names, faces, and personalities of past and present leaders and "hewers of wood." Throughout the book extensive and pertinent vignettes of people add to the human character of the story.

To enumerate all the pioneer responsibilities of the USPHS in this review is obviously impossible. The establishment of the first Marine Hospital Service, however, on July 16, 1798, for the care of sick and disabled seamen deserves special mention as the origin of what we now know as the United States Public Health Service. Of almost equal importance it underlines the fact that this period witnessed the first prepaid medical care program in the United States via a tax of twenty cents a month on American seamen to provide for medical care. It carried a lesson, even a century and a half ago, that the prepayment was sadly insufficient for the purpose—a lesson which this and other countries are rediscovering the hard way in our own prepayment medical plans.

The list of diseases in which the Service played significant parts in diagnosis, control, and treatment includes almost every familiar dramatic scourge of the nineteenth century—smallpox, yellow fever, cholera, plague, et cetera. The second half of the twentieth century brings new challenges, equally dramatic and perhaps more complex and subtle, in identification of cause and in development of prevention and cure. The next decades will test the mettle of the Service to match the glories of the past.

The section dealing specifically with nurses and nursing is disappointing both in coverage and in interpretation. Only three and a half pages are devoted to this function although scattered throughout the volume are references to nursing activity. The contributions of the nurse to public health and medical and hospital practice are recognized but not amplified. Special references to the activities of leaders such as Minnigerode, Daly, Fauquier, Hill, McIver, and Petry, record these active

workers for nursing history but the development of their significance is somewhat barren and largely statistical. A corps which now numbers almost 1,600 deserves elaboration and perhaps must await the second volume of this history.

One of the most striking impressions on reading the volume, at least for this reviewer, is the vast amount of exciting and fruitful scientific contributions made by the USPHS from the early nineteenth century up to 1940 with a handful of investigators and, by present criteria, with only a handful of budget! Is there an important lesson in this record for the leaders of the next half-century?

This volume should be followed by a companion one, which would be interpretive and diagnostic in character and which would draw from Dr. Williams' mine of information the lessons of a century and a half on the recruitment of people, the significance of governmental responsibility, the impact of budget, the scope of operations, and the philosophy which guided the search for truth.

—ABEL WOLMAN, DR. ENG., *Professor of Sanitary Engineering, The Johns Hopkins University.*

GENERAL

PLASTIC SURGERY. C. R. McLaughlin, M.B., Ch.B., F.R.C.S.E. Philadelphia, J. B. Lippincott Company. 1951. 125 p. $3.00.

HEALTH AND HUMAN RELATIONS IN GERMANY. Report of the second conference on problems of health and human relations in Germany held in Williamsburg, Virginia, December 1950. The Josiah Macy, Jr., Foundation, 565 Park Avenue, New York 21, New York. 1950. 30 p. $1.00. Members of the Princeton group (first conference) and fifteen Germans discussed the Princeton conference report and made recommendations on problems regarded as basic to the development of sound relationships between Germans and the peoples of the Western nations.

HOW YOU GROW. Bernice L. Neugarten. Science Research Associates, Inc., 57 West Grand Avenue, Chicago, Illinois. 41 p. 40c. First of Junior Life Adjustment Booklets designed to be read by children in grades six to nine. It gives them some idea of what to expect as they go through their growing-up period

FOR FATHERS WHO GO TO WAR. Loyd W. Rowland, Ph.D. Louisiana Society for Mental Health, 816 Hibernia Building, New Orleans, Louisiana. 10 p. 25c. Addressed to the serviceman, this pamphlet contains suggestions for maintaining contact with his family and suggests some of the things he can expect from the young children when he returns home.

NURSING EDUCATION

APPLIED ANATOMY FOR NURSES. E. J. Bocock, S.R.N., and R. Wheeler Haines, M.B., D.Sc. Baltimore, The Williams and Wilkins Company. 1951. 320 p. $3.50.

HEALTH EDUCATION

COMMUNITY HEALTH EDUCATOR'S COMPENDIUM OF KNOWLEDGE. Clair E. Turner, Ed.M., Dr.P.H. St. Louis, The C. V. Mosby Company. 1951. 266 p. $3.00.

NURSING

A MANUAL OF SIMPLE NURSING PROCEDURES. Mary J. Leake, R.N. Philadelphia, W. B. Saunders Company. 1951. 65 p. $1.25. Emphasizes brevity and simple step-by-step breakdown of fundamental nursing procedures and is aimed at facilitating the training of nurses aides, et cetera. In outline form with many helpful line drawings.

SCHOOL HEALTH

ANNUAL REPORT OF THE HEALTH SERVICE DEPARTMENT, SCHOOL YEAR 1949-1950. Leland M. Corliss, M.D., and Kenneth E. Oberholtzer. Denver, The Denver School Press. 27 p. Free from Health Service Department, Denver Public Schools, 414 14 Street, Denver 2, Colorado. A report of the work of the Health Service Department which includes statistical information on services to pupils, teachers, and other school personnel. Tells also of cooperation with community health and welfare agencies in trying to develop better mental and physical health and thus better learning in children.

SCHOOL DAYS. New York, New York City Department of Health. 1951. Free. This valuable reference booklet for New York City parents assures them that a friendly welcome awaits their children entering school, provides hygiene advice, points out that emotional security at home builds success at school, urges parents to consult the teacher rather than scold or punish children, and reminds them that a city bureau of child guidance is available.

FROM NOPHN HEADQUARTERS

STRUCTURE TIMETABLE

March 1952: Copies of the proposed bylaws for the new National League for Nursing were sent to all NOPHN members with their proxy vote on reorganization. The NLNE also sent its members copies of the proposed NLN bylaws and the ANA sent copies of the proposed revisions of the ANA bylaws to its voting body.

April 1952: The annual conference of the AAIN was held in Cincinnati April 21-25. We go to press too early to report in this issue the action on reorganization of the AAIN membership.

Sunday afternoon, June 15: A Forum on Structure will be held in Convention Hall from two to four o'clock for all who are at the convention. After the forum NLNE members will meet to discuss the proposed bylaws of the NLN.

Monday morning, June 16: The second session of the Forum on Structure will be held from nine to eleven-thirty for all who have registered at the convention. During the afternoon members of the Association of Collegiate Schools of Nursing (ACSN) NLNE, and NOPHN will discuss the proposed bylaws of the new NLN. NLNE members will then begin to vote on the NLN bylaws because the boards of directors of the national organizations have agreed that the NLNE shall be the legal nucleus for the NLN. During the NLNE meeting a resolution will be offered to amend the NLNE Certificate of Incorporation. The ACSN members will vote on reorganization during their meeting.

Monday evening, June 16: The ANA House of Delegates will begin to consider the proposed revisions of the ANA bylaws, some of which are designed to provide for structural reorganization.

Tuesday evening, June 17: NLNE members will continue to vote on the proposed bylaws of the new NLN during a business meeting.

Wednesday, June 18: It is expected that NLNE members will have completed action on the NLN bylaws.

Thursday, June 19: During a morning business meeting NOPHN members will vote on the proposal that the National Organization for Public Health Nursing dissolve and transfer its membership and assets to the new National League for Nursing.

Friday, June 20: NLN members will hold their first business meeting.

Saturday, June 21: The NLN Board of Directors will meet for the first time. The new ANA board also meets.

* * *

In January 1952 the ANA board authorized the establishment of a national section for public health nurses as proposed in the structural reorganization. Preliminary meeting for those interested in this new section will be held Tuesday, June 17, from 4:15 to 5:15 p.m. An organizational meeting will be held on June 18 at the same hour. Suggestions for the offices to be filled—chairman, vice-chairmen, secretary—are wanted.

ROUNDUP OF CONVENTION NEWS

We're able to fill in several of the blank spots in the tentative program for the Biennial Convention (February issue, page 116). On Monday, June 16, from 4:15 to 5:15 p.m., there is to be a program meeting on civil defense. The speakers are Dr. Norvin Kiefer, director, Health and Special Weapons Defense Division, and Mrs. Frances Crouch Nabbe, nursing consultant, Federal Civil Defense Administration. They will discuss the overall federal plan including nursing participation in the civil defense program.

Two of the NOPHN sections are sponsoring programs. The meetings are open to all, nurses and nonnurses. At the Nurse Midwifery Section meeting on Wednesday morning, June 18, consideration will be given to the psychosomatic aspects of the maternity cycle. Dr. Betsy Wootten of Baltimore,

Dorothy Jump and Vera Keane of Cornell University-New York Hospital School of Nursing, and Mary Edna Fitzpatrick, hospital nursing consultant, Georgia State Department of Public Health, are the scheduled speakers. The follow-up discussion will be led by Hazel Corbin and Hattie Hemschemeyer of Maternity Center Association in New York.

Thursday evening from 8 to 10 p.m. trends in school nursing services will be discussed at a meeting of the School Nursing Section. Dr. Samuel Wishik will discuss trends in school health services, and various aspects of school nursing services will be presented by an urban and a county school administrator, a parent, a teacher, and a nurse. Florine N. Thomason of Richmond, Virginia, will be the nurse participant in this discussion. A group of nurses representing all sections of the United States will then tell about what is happening in school nursing in their areas. In this way a picture of school nursing will be developed.

This is really a flash report! We have just learned that Mr. Benjamin Cohen, assistant secretary-general, Department of Public Information, United Nations, has accepted the invitation to address the convention at the joint program meeting Wednesday night. Needless to say, we are delighted to tell you this splendid news.

This year we are all to be in the movies! Through the courtesy of Wyeth, Incorporated, the highlights of the convention are to be filmed. The black and white 16 mm film—running time thirty minutes—will be available for nursing meetings after September 1. The Film Committee has been hard at work previewing and selecting films to be shown in Atlantic City. There will be showings Monday through Thursday from 4 to 6 p.m. The chosen films emphasize human relationships.

The technical exhibit will be one of the finest ever assembled for a nursing meeting. You had better plan several visits to Exhibit Hall Monday through Thursday.

The board and committee members lounge will be located right next to the NOPHN booth in Convention Hall. The Records Room, always a popular place, will be close to the booth, too. You'll want to schedule some free time to go over what's new in records and reports.

Don't take a chance at being disappointed. The Rally Dinner tickets will go quickly and the number is limited. Buy yours early. The dinner is planned for Tuesday evening, 6:30 to 8:30, in the Carolina Room, Chalfonte Hotel. Look back to page 241, April issue, for details about the Rally. A good time is practically guaranteed to all who attend.

Bring your NOPHN *membership card with you.* NOPHN members will be given an NOPHN badge when they register. You will need your badge for admission to NOPHN business meetings.

LET US RESOLVE

At each Biennial Convention the NOPHN members accept a series of resolutions which indicate their concern in certain areas of health and their interest in promoting certain developments and programs. The Committee on Resolutions for the 1952 Biennial Convention has just been formed with Margaret L. Shetland as chairman. Miss Shetland is anxious to have suggestions for topics for resolutions from public health nurses everywhere. Will you share your ideas with Miss Shetland and her committee members? Write as soon as possible to Miss Shetland at the NOPHN office.

NLN STAFF

Agnes Gelinas, chairman of the Committee on Agreements for the National League for Nursing, announces that Marion W. Sheahan, at present director of the National Committee for the Improvement of Nursing Services, will become director of the Division of Nursing Services in the new National League for Nursing, if structural reorganization of the national nursing organizations takes place at the Biennial Convention.

The NCINS is concerned with the improvement of nursing service and nursing service administration. With the appointment of Miss Sheahan to the new Division of Nursing Services the work of the NCINS will be inte-

grated into the program of the ongoing Division of Nursing Services of the NLN with the continuity of its program assured.

As announced previously, Julia Miller will become director of the Division of Nursing Education in the National League for Nursing and Anna Fillmore will become general director of the new organization, if reorganization proceeds according to schedule. Directors of departments in NLN will be announced later.

NURSING IN MEDICAL CARE PLANS

At the January meeting of the NOPHN Board of Directors the following resolution was passed:

Whereas, the President of the United States has by executive order established on December 29, 1951, a Commission on the Health Needs of the Nation; and

Whereas, the President stated that "many vital problems remain unanswered, such as insuring an adequate supply of physicians, dentists, nurses, and allied personnel; developing local public health units throughout the nation; making more hospitals and hospital beds available where needed; stepping up the tempo of fundamental medical research; meeting the needs of the chronically ill and the aged; and providing adequate diagnostic, rehabilitative, and other services to all income groups;" and

Whereas, the National Organization for Public Health Nursing is aware that public health nurses are able in many areas of the nation to make specific contributions to meeting the needs of the chronically ill and the aged, and to facilitate the convalescence and rehabilitation of patients through well operated public health nursing services in the home; and

Whereas, the presence of such nursing services within communities contributes appreciably to the reduction of the number of days needed for hospitalization for many conditions and to the more rapid return of the individuals to useful function in society; and

Whereas, such services make an appreciable contribution to the economic welfare and well-being of the nation; be it therefore

Resolved: That the Commission on the Health Needs of the Nation be urged to study (1) the possibility of having more effective and economical medical care through the extension of public health nursing services in the field of home care and (2) the desirability of closer liaison between hospital medical services, public health nursing services, and prepaid medical care plans.

A copy of the above resolution was sent to Dr. Paul B. Magnuson, chairman of the Commission on the Health Needs of the Nation.

MEMBERSHIP NEWS NOTE

Special congratulations this month to Toledo (Ohio) District Nurse Association and the Public Health Nursing Service of the Civic League and City of Bay City (Michigan) for 100% staff membership in NOPHN for each of the past twenty-five years.

Other 1952 one hundred percenters are:

Alabama
Huntsville—Madison County Public Health Department
Illinois
Champaign—Champaign-Urbana Public Health District
East St. Louis—Visiting Nurse Association of St. Clair County
Rockford—Visiting Nurse Association
Maine
Northeast Harbor—Mt. Desert Public Health Nursing Association
New Jersey
Hackensack—Central Bergen Visiting Nurse Service
Pennsylvania
Scranton—Visiting Nurse Association of Scranton and Lackawanna County

ABOUT PEOPLE YOU KNOW

The College of Nursing and Health, University of Cincinnati, announces the following faculty appointments: *M. Corinne Bancroft* as assistant professor in charge of pediatric nursing programs for graduate nurses; *Mildred V. Wallace,* instructor in charge of clinical instruction in pediatric nursing programs for graduate nurses; *Sylvia A. Ginsberg,* assistant professor in charge of programs in psychiatric nursing for graduate nurses. . . *F. Marie McConnell* was appointed to the nursing field staff of the Eastern area, ARC, and will be assigned to southern Indiana. . . . *Mary V. Adams,* who was on the faculty of Duquesne University in 1950, is now director of the VNA of Stamford, Connecticut.

Mary E. Grotty, formerly on the staff of the New York City Health Department, has accepted the position of educational director, St. Mary's School of Nursing, Orange, New Jersey. . . . The Veterans Administration announces the assignment of *Margaret Reeve* as chief, nursing unit at the VA office, Birmingham, Alabama. Miss Reeve was pre-

(Continued on page 302)

The Initial Board of Directors of the National League for Nursing

The Joint Board of Directors of the national nursing organizations on January 26, 1952, approved a slate of nominations for the initial Board of Directors of the new National League for Nursing. (See below) According to the proposed plan for NLN this board will be elected as a fixed slate by the membership at the first meeting of NLN on June 20, 1952.

The term of office for members of the initial Board of Directors shall be until the final business meeting of the 1953 Biennial Convention, when a new Board of Directors shall be elected by the members. (See Article XXIII, proposed bylaws of NLN, *American Journal of Nursing*, April 1952.)

The initial officers of the organization shall be elected by the members of the initial board after the election of the board itself at the first meeting of NLN on Friday, June 20, 1952.

Each of the four organizations that will form the nucleus of the National League for Nursing nominated four nurses currently serving on its board and two nonnurses currently serving on the board—or appointed by it if there were not two nonnurses on the board. Among the factors considered in making the nominations were the desirability of providing continuity of experience and service, wide geographical distribution, and representation from as many types of service agencies and educational programs as possible.

Slate Nominated for Initial Board of Directors of NLN

National Organization for Public Health Nursing

Emilie G. Sargent, R.N.
Visiting Nurse Association
Detroit, Michigan

Willie Mae Johnson, R.N.
Montclair Public Health Nursing Service
Montclair, New Jersey

*Mrs. H. Stanley Johnson
Madison, Wisconsin

Mrs. Olive W. Klump, R.N.
County Health Department
Los Angeles, California

Dorothy Wilson, R.N.
Visiting Nurse Association
New Haven, Connecticut

*Mr. L. Meredith Maxson
New York, New York

National League of Nursing Education

Agnes Gelinas, R.N.
Department of Nursing
Skidmore College
New York, New York

Henrietta Doltz, R.N.
School of Nursing
University of Oregon Medical School
Portland, Oregon

*Mrs. Genevieve K. Bixler
Des Moines, Iowa

Mildred I. Lorentz, R.N.
School of Nursing
Michael Reese Hospital
Chicago, Illinois

Ruth Sleeper, R.N.
School of Nursing
Massachusetts General Hospital
Boston, Massachusetts

*Mrs. Mae O. Spiegel
Chicago, Illinois

American Association of Industrial Nurses

Helen R. Dixon, R.N.
General Motors Corporation
Rochester, New York

Elizabeth Lafferty, R.N.
Socony Vacuum Oil Company
Paulsboro, New Jersey

Margaret C. Glennon, R.N.
H. K. Porter, Inc.
Somerville, Massachusetts

Gertrude A. Stewart, R.N.
International Business Machines
Washington, D.C.

*Mr. Edward Handelman
New York, New York

*William A. Sawyer, M.D.
Eastman Kodak Company
Rochester, New York

Association of Collegiate Schools of Nursing
Elizabeth S. Bixler, R.N.
Yale University School of Nursing
New Haven, Connecticut

Julia Hereford, R.N.
School of Nursing
Vanderbilt University
Nashville, Tennessee

*Francis J. Brown, Ph.D.
American Council on Education
Washington, D.C.

Sister Charles Marie, R.N.
Department of Nursing Education
Incarnate Word College
San Antonio, Texas

Frances C. Thielbar, R.N.
Division of Nursing Education
University of Chicago
Chicago, Illinois

*George B. Darling, Dr.P.H.
Division of Medical Affairs
Yale University
New Haven, Connecticut

* Denotes nonnurse members. See the *American Journal of Nursing*, May 1952, for biographical data of all the nominees.

About People

(Continued from page 300)

viously a consultant, Georgia Department of Public Health. . . . *Frances Hillman* is the newly appointed mental health nurse consultant, Instructive District Nursing Association, Columbus, Ohio. . . . *Dorothy Weddige* has succeeded Mary Ellen Manley as director of nursing education and nursing service, New York City Department of Hospitals. *Mary E. Mullen*, former director of education, Kings County Hospital School of Nursing, is now assistant to Miss Weddige.

Two USPHS officers, *Emily Myrtle Smith* and *Genevieve Soller*, are the first nurses assigned to Formosa and the Philippine Islands under the Mutual Security Agency program. Miss Smith is to be stationed in Taipeh and Mrs. Soller in Manila. Miss Smith has been assigned since 1949 to Columbia and Yale Universities where she set up advanced courses in industrial nursing hygiene in the respective schools of public health. Mrs. Soller has been assistant chief of the Cancer Nursing Section, USPHS, since 1950. The USPHS announces also the assignment of *Lillian Bischoff* as chief nurse to the Point Four mission in New Delhi, India. Miss Bischoff lately was associate director of public health nursing, Georgia State Department of Public Health. She was chief nurse to the WHO mission in Addis Ababa from 1945 to 1948.

NOPHN FIELD SCHEDULE—APRIL

Anna Fillmore	Baltimore, Md.
Marjorie L. Adams	Framingham, Sudbury, Needham, Attleboro, Wakefield, Canton, Mass. Somerville, Verona, N. J.
Helen Connors	Albany, N. Y. New Haven, Conn. Harrisburg, Pa.
M. Olwen Davies	Providence, R. I.
Ruth Fisher	Brooklyn, N. Y.
Frances E. Goodman	Charlotte, N. C.; Shreveport, New Orleans, La.
Helen S. Hartigan	Covington, Ky.; Wellesley, Mass.; Alexandria, Shreveport, New Orleans, La.
Bessie Littman	Portland, Me. Providence, R. I.
Grace K. Luby	Camden, N. J.; Memphis, Tenn.; Jackson, Pascagoula, Miss.; Mobile, Ala.
Eva M. Reese	Atlanta, Ga. Camden, N. J.
Dorothy Rusby	Richmond, Va. Brooklyn, N. Y.
Jean South	Canton, Lisbon, Ohio Richmond, Va.
Louise M. Suchomel	Springfield, Mass.
Marie Swanson	Arlington, Va. Washington, D.C.
Judith E. Wallin	Nanticoke, Pittston, Pa. Wheeling, W. Va. Huntington, W. Va.

March field trips not previously reported: Marjorie L. Adams, Holden, Mass.; Mary Elizabeth Bauhan, Orange, N. J.; Bessie Littman, Washington, D.C.; Eva M. Reese, Washington, D.C.; Judith E. Wallin, Norristown, Pa.

NEWS AND VIEWS

C. D. IN GENERAL HOSPITALS

The care of patients with communicable disease has posed a special problem in the field of medical care for many centuries.

The decrease in virulence of some disease-producing organisms, the development of extensive and intensive immunization programs, the improvements of laboratory diagnostic procedures, and the development of new antibacterial and antiviral forms of therapy have thrown the isolation hospitals out of gear with community needs. In spite of these scientific facts appropriate changes have not been made in community planning to provide the best medical care at reasonable cost to patients with communicable disease.

In 1948 the Committee on Research and Standards of the American Public Health Association reexamined the broad problem of the care of the hospitalized cases of communicable disease. Its report indicated that there was great variation in the policies of general hospitals in the United States about admitting known cases of communicable disease or caring for those identified after admission. It was also evident that there was no uniformity in technics employed and that many procedures established years ago were no longer in keeping with present knowledge or were justified by the contribution that they might make to the prevention of disease. The committee proposed that the APHA meet with representatives of other official and voluntary medical, nursing, and hospital organizations to explore the possibility of making a joint statement about this problem. Such a conference was held in April 1951 and the following is abstracted from the summary of the conference.

1. *The medical profession has a responsibility to interpret the facts about communicable disease* to the related professional groups and to the public at large.

2. *It is desirable and feasible for many cases of communicable disease to be cared for at home.* The following questions should be asked before a patient with a communicable disease is hospitalized as a routine procedure: (1) does this patient need hospital care in order to recover (2) are there any social reasons why the patient can't be cared for at home (3) are there community resources which are not being used for home care (4) will hospitalization contribute to the control of the disease and prevent it from becoming "epidemic."

3. *Communicable disease should be cared for in general hospitals.* The purpose of hospitalizing a patient with communicable disease is to furnish the best possible treatment available. This can best be done in a general hospital where the overall diagnostic and therapeutic facilities are of a high order because they are used daily for a wide variety of other types of patients. Consultation is more readily available in large general hospitals. When medical and surgical emergencies arise the general hospital is better prepared with specialized equipment and better staffed to care for them in a routine manner. Many general hospitals are routinely accepting cases of communicable disease and are competent to do so. Others could do the same if they weren't handicapped by archaic hospital regulations, outdated medical attitudes, or an uninformed laity.

4. *There is need to make clinical material more extensively available.* As clinical material in isolation hospitals has decreased a smaller proportion of nurses and interns have had experience in communicable disease. By hospitalizing cases of communicable disease in general hospitals this smaller amount of clinical material can be made available for the preparation of larger numbers of professional personnel.

5. *All medical personnel should have basic training and experience in the care of communicable diseases.* If all physicians and nurses were well prepared, tested for suscepti-

bility, immunized against communicable disease whenever possible, well oriented in the field, then much of the fear and needless mystery would disappear and all physicians and nurses would be prepared to cope with communicable diseases when and wherever they appear.

6. *There is a need for the promulgation of general and minimum standards in the care of communicable diseases in general hospitals and in the home.* A manual for the care of communicable diseases in general hospitals should be prepared and made available as a guide to communities.

NLNE BIBLIOGRAPHIES

The latest in the NLNE series of annotated bibliographies are now available: Number 9, covering Professional Adjustments, Economic Background and Economic Security, Legislation and Legal Aspects of Nursing; and Number 1, covering Anatomy and Physiology, Chemistry, Microbiology, Physics.

These publications may be ordered from NLNE, 2 Park Avenue, New York 16. Price $1.50 each.

FILMS ON CHILD LIFE

Motion Pictures on Child Life, a list of films relating to all aspects of childhood, has just been made available by the Children's Bureau and may be purchased from the Government Printing Office, Washington 25, D.C. Price 40 cents. The films are listed under such headings as adolescence, child care, child development, juvenile delinquency, mental health, and nutrition.

POLIO NURSING CONFERENCE

A polio nursing conference held November 26-27, 1951, was called at the request of NFIP to discuss current problems in providing adequate nursing service and improving nursing care for poliomyelitis patients. The following topics were discussed: planning and education, local nursing needs, recruitment, general nursing problems. The group recommended that polio planning committees should be established and utilized in all states; that two nursing groups—instructors in schools of nursing responsible for teaching care of polio patients, and supervisors and head nurses or their assistants directly concerned with the responsibility for care of polio patients—should have top priority in educational programs offered in the care of polio patients; that the ARC should continue to carry responsibility nationally for recruitment of nurses for the care of polio patients; that hospitals should maintain adequate nursing staff to care for polio patients and priority for special care should be in proportion to the severity of the illness.

For further information about the results of the conference write to JONAS, 2 Park Avenue, New York 16.

NURSING IN CIVIL DEFENSE

The Maryland Department of Health has just released parts 3 and 4 of the Suggested Content for the Training Program in Civil Defense Nursing. Part 3 discusses the preparation of nurses for emergency activities through review demonstration and practice. Part 4 is entitled The Integration of Nursing in the Total Civil Defense Program. The two parts, stapled together in one volume, may be purchased for one dollar. Order from the Division of Public Health Nursing, Maryland Department of Health, 2411 North Charles Street, Baltimore 18.

SOURCE MATERIAL ON CIVIL DEFENSE

An Annotated Civil Defense Bibliography for Teachers, published by the Federal Civil Defense Administration, is now available from the U. S. Government Printing Office and is being distributed to civil defense directors of the states and territories and to FCDA regional directors. The publication is designed primarily for the nation's educators. The material listed is classified for levels of study—elementary, secondary students, and adults—under such subject headings as general civil defense information, schools and civil defense, atomic energy and its uses, survival from attack: atomic, biological, chemical, high explosive and incendiary bomb, and first aid.

For dot news, see page A12

Our Readers Say . . .

FROM ISRAEL

Being particularly interested in pediatric nursing I was delighted when I answered a help wanted ad and was successful in securing a position in a new government hospital in Jaffa that consisted of pediatric and obstetric wards. The hospital had previously been owned by an Arab doctor and had apparently catered to a wealthy clientele, for it was delightfully situated in a well tended garden, with huge glass windows in every room, and the appointments were good, generally speaking. However, there were no plumbing or kitchen facilities.

The first few months were hectic. There was a critical shortage of hospital beds, for immigrant children were coming in in tremendous numbers, and most of them were usually in critical condition, with malnutrition almost always a complicating factor. The most common diagnoses were acute gastroenteritis, typhoid fever, pneumonia, and malaria. We also saw many cases of tuberculosis—pulmonary, miliary, and ostial, meningitis, and bacillary dysentery, as well as the more common respiratory and cardiac conditions found in most pediatric wards in the United States. These cases were not segregated at first, but now we have a special ward for tuberculous children and use strict isolation technic in caring for the typhoid fever and dysentery cases.

The mortality rate was frighteningly high because of the almost moribund condition of the children upon arrival. But this situation gradually improved as our bed capacity increased and other pediatric wards were opened in immigrant camps. In a reasonably short time we had a pediatric ward of about forty beds.

At first the kitchen was in the basement. The refrigerator was of ancient vintage and required frequent repairs and continual attention. The cooking was done on a small three-plate electric burner and when the electricity was cut off or the burner was out of order—which was not infrequently—we had to use small kerosene stoves. During this initial period workers were busy installing sanitary facilities, painting, et cetera, and the attendant noise and confusion were not particularly conducive to the patients' rest and comfort.

The children—almost all new immigrants ranging in age from a few days to four or five years—were indescribably pathetic, malnourished, and usually dirty specimens of humanity, but it was amazing to see in what a short time they began to fill out and take more interest in life. Many of those over a year old were unable to eat hospital food, having been accustomed mainly to pitta, a type of flat Arab bread. I remember one boy, fifteen months old, who did not yet sit up alone, who stonily refused all food for several days. By the time he had been persuaded to drink the buttermilk which was ordered because of his gastroenteritis, he was permitted to eat cereal—which started another battle with him. However, after two and a half months he was sitting and even standing alone and eating voraciously anything he could get his hands on, including sweets that were brought to other children.

As time passed our equipment improved, the rooms took on a professional appearance, and a second wing was opened in a nearby building. I believe that the hospital today compares favorably in the quality of care given to patients with that of many hospitals in the United States and I am sure that treatments incorporate the latest advances in therapy, although antibiotics are in very short supply. However, there is an acute shortage of professional nurses and an exceedingly heavy workload, so that there is a certain lack of a well integrated approach to the whole patient and far too little time spent in ministering to the children's need for attention and affection.

For real satisfaction in nursing this pioneer period has never been equaled. The ten months I worked there were among the busiest and most tiring of my nursing career, but I recall those hectic times with mixed pleasure and regret and frequently wish I could once again have the opportunity to take part in that most essential and urgent task—restoring health to Israel's immigrants.

MRS. SHOSHANNAH VARDI
Krutzat Nir Etzion
P.O.B. 1251, Haifa, Israel

PRACTICAL NURSES IN A VNA

As there was a good deal of interest in our plan for using practical nurses, which I described in Practical Nurses, Of Course We Employ Them (PUBLIC HEALTH NURSING, December 1950, page 663) I thought public health nurses would like to know about a new policy. This relates to the administration of subcutaneous and intramuscular injections by practical nurses. The following was approved by our Medical Advisory Committee and adopted by our Board of Directors in December 1951.

Practical nurses may give subcutaneous and intra-

muscular injections under the following conditions: The area supervisor must give her permission for *a specific practical nurse* to give the drug to *a specific patient*. Her permission can be given only if:

1. Measurement of the drug can be done simply by using whole tablets or ampules, or accurately determined in units, minims, or ccs on the syringe. *Practical nurses may not compute fractional dosage.*

2. The medication has already been administered previously by a public health nurse in the employ of the VNA and no unusual circumstances were encountered.

3. The medication is not a vaccine.

4. The patient's and family's physical and emotional reactions to the idea of treatment and to having it given by a practical nurse are satisfactory.

5. The supervisor is well aware of, and has met the individual practical nurse's needs for instruction (including observation and practice under supervision) and knows her skills in preparing the syringe and medication, in administering it and recording it, and is confident that she can safely give it.

ELISABETH C. PHILLIPS, R.N.
Executive Director,
Visiting Nurse Association
Rochester, New York

Abstracts

(Continued from page 293)

syphilis, their family and community interests, and their emotional and vocational orientations. Respondents interviewed were asked whom they consulted for advice about their venereal disease symptoms and the nature of the advice received. It was learned that persons infected with syphilis tended to talk about their health problems with certain friends and relatives and most frequently consulted the Negro mother. Both men and women received the poorest advice from their own spouses.

In areas with a high prevalence of venereal disease the nonvolunteers constitute a major problem in a venereal disease control program. The outstanding characteristic of these people was apathy toward their infection. Nonvolunteers are both geographically and psychologically isolated people. They have less schooling than the volunteers and are more likely to come from a poor economic stratum of the population. They are less inclined to look after their own welfare, but look instead to others to provide answers to their daily problems.

The ratio of volunteers to nonvolunteers was about two to one. The average volunteer waited sixteen days before seeking medical diagnosis, and almost half had waited until after the appearance of a second symptom before seeking diagnostic help. The average nonvolunteer was not found until three weeks after the first venereal disease symptom appeared.

Most persons in the syphilitic population possessed some correct information about the cause, symptoms, and the possible outcome of syphilis. Male and female nonvolunteers differed sharply in their knowledge of syphilis. Male volunteers and nonvolunteers could not be distinguished on the basis of their knowledge of the subject. However, the reverse was true for women. Women with much knowledge of all aspects of venereal disease volunteered in great force. Those with little knowledge were most often nonvolunteers. Concern over the social stigma of having a venereal disease did not distinguish volunteers from nonvolunteers. Concern over the damage and discomfort which these diseases may cause, the level of information which respondents have about these diseases, and the prior experiences of respondents in solving their own personal problems, all played significant roles in determining which persons volunteered for diagnosis of their infections and which did not.

Abstracted from Case Finding through an Understanding of Known Syphilitic Patients by Gray, A. L., Bauer, Theodore J., and others, in *Journal of Venereal Disease Information*, June 1951.

ICE CREAM— a nourishing food and so good to eat

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For oldsters and youngsters—ice cream offers many essential nutrients in a palatable and "easy-to-eat" form.

Surveys show that when people tend to decrease their food intake as they grow older, they often do so by omitting foods hard to prepare or eat. While a reduction in calories may be advantageous, there also may be an undesirable reduction in the intake of certain nutrients—particularly calcium and protein.[1]

Ice cream supplies calcium and high-quality protein, and other important nutrients apt to be lacking in limited diets. It is an excellent food for older people, for ice cream tastes good, is easy to eat, is highly digestible, and its nutrients are readily available to the body.

For the same reasons, ice cream is a good food for children, too. Children love ice cream—and frequent and continued use does not decrease its popularity. This was clearly demonstrated in a study in a boarding school, in which this food was served at least twice a week for more than a year. It was eaten with unfailing enthusiasm. Directors of the project stated that ice cream was "psychologically a great boon . . . helped lend tone to the project as nothing else could."[2]

High nutritive value plus delicious flavor—the combination makes ice cream a favorite food for all.

1. Ohlson, M. A., Roberts, P. H., Joseph, S. A., and Nelson, P. M. *Dietary practices of 100 women from 40 to 75 years of age.* J. Am. Diet. Assn. *24*:286 (April) 1948.

2. Roberts, L. J., Blair, R., and Greider, M. *Results of providing a liberally adequate diet to children in an institution. I. Acceptance of foods and changes in the adequacy of diets consumed.* J. Pediatrics *27*:393 (Nov.) 1945.

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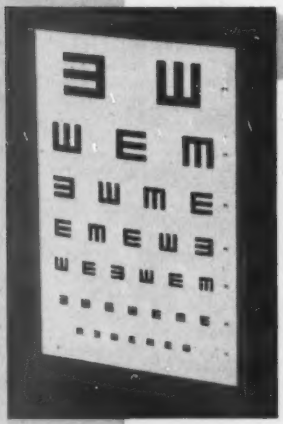

STEP 1

VISUAL ACUITY, the most important part of the screening program, can be done with greatest confidence with this chart, because the testing letters are accurate in size and shape, embedded between two sheets of hard plastic that can be washed repeatedly and are illuminated by a daylight fluorescent bulb and screened so as to produce an even distribution of 20-25 foot candles over the surface. (10 foot candles can be had on special order if desired.) Letter sizes 20/15 to 20/100 in children's E card or alphabetical card for 20 foot use. Also a reversed card for indirect or ten foot use with mirror.

Chart is 9 by 14 inches, comes complete with metal cabinet and bulb, ready to plug in. Weighs only 4 pounds and may be hung on wall or set on a table. Eye chart complete with children's E card.....$22.50
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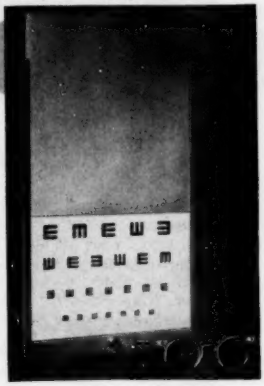
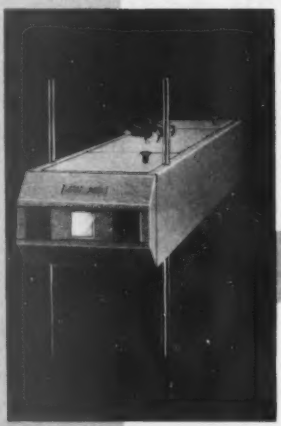
STEP 2



HYPEROPIA TEST, or far-sightedness test. This test uses the same chart, except the top lines are blocked off with a piece of cardboard showing only the 20/40 and smaller lines. Plus 2.00 glasses are used for fifth grade through eighth grade. About 10% of the children will be able to read the 20/40 line and about 3% the 20/30 line. Those that can read these lines are far-sighted and may be referred for correction if they are obtaining less than average grades in school. If children wearing glasses are screened, the plus 2.00 lenses are placed over their own glasses for the test.
Plus 2.00 glasses.....$8.00



STEP 3

MUSCLE AND SUPPRESSION TEST. This test is to detect about 2% of the younger children who have either poor co-ordination of their eye muscles or suppress or ignore the sight of one eye. This test need not be given every year and for that reason a special piece of equipment has been designed so that it may be shared by many schools, and thus not incur the extra expense for each eye chart. The advantages are that neither special Maddox rod glasses nor a dark room are required for the test. It is so simple to operate that even kindergarten children give reliable answers. This is important because it is in the younger children that the incidence is higher and the improvement from early treatment is most effective.

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1. Behrman, H. T., Combes, F. C., Bobroff, A., Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
2. Turell, R.: New York St. J.M. 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer B.: Archives Pediat. 68:382, 1951.

POSITIONS AVAILABLE

Advertisements in this column are accepted at the following rates: 10c a word with a minimum of $3 for 30 words or less, MONEY TO ACCOMPANY ORDER FOR INSERTION. Agency members or sustaining members may have ONE insertion up to 50 words without charge. Closing date for copy and cancelation is the 1st of the month previous to publication.

DIRECTOR: visiting nurse association; excellent personnel policies; retirement plan; Social Security; program includes bedside care, tuberculosis, maternal, child health, classes, and conferences; NOPHN requirements. Write to Mrs. Dan Ernst, 155 Fremont Street, Dubuque, Iowa.

EXECUTIVE: generalized public health nursing program for private agency in large Southern city; salary $5,000-$6,000, depending on training and experience. Write to Box 552, PUBLIC HEALTH NURSING, 2 Park Avenue, New York 16, New York.

INSTRUCTOR and assistant to executive director: 7-nurse staff, undergraduate students; generalized service; bedside nursing; family health; 40-hour week; retirement; Social Security; hospitalization plans; salary $3500; age limit 40. Write to District Nurse Association, 51 Broad Street, Middletown, Connecticut.

PUBLIC HEALTH NURSES: general rural program; salary: public health nurses, $2852-$3536; graduate nurses as assistant PHNs, $2540-$2972; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Mrs. Earle W. Gibbs, State Health Department, Richmond, Virginia.

SUPERVISOR: public health degree required; city health department; generalized nursing program; salary $4,200 a year; travel allowance $30 a month; state qualifications and experience. Apply to Mr. H. J. Zinkel, Chairman, Board of Health, 918 South 24 Street, Manitowoc, Wisconsin.

STAFF NURSES: generalized service with visiting nurse association; salary $2,600-$3,000 annually, depending on qualifications, experience; 30 days vacation yearly; sick leave; liberal allowance on car; educational opportunities for interested beginners. Write to Executive Director, Visiting Nurse Association, 1715 Crawford Street, Houston 3, Texas.

STAFF NURSES: generalized program in rural resort area of southwestern Michigan; starting salary for nurse with desired qualifications $3,120; $60 increase at end of 6 months and semiannual salary increments thereafter; travel allowance $36 a month plus 4c a mile; 4 weeks vacation; Social Security; liberal personnel policies; active public health training center. Write to A. B. Mitchell, M.D., Medical Director, Van Buren County Health Department, Paw Paw, Michigan.

SUPERVISORS and CONSULTANTS: public health training required; salaries $225 to $365; established personnel policies.

Also STAFF NURSES: generalized service in local health departments; individualized placement; salaries $220 to $250; travel allowance for use of personal car; vacation allowance; sick leave.

All positions: 40-hour week; opportunities for further training. Write to John I. Hogue, Merit System Supervisor, 313 Wallace Building, Little Rock, Arkansas.

PUBLIC HEALTH NURSE: generalized program in rural area, Southern California; car furnished; salary $326 a month. Write to Thomas E. Patton, M.D., Imperial County Health Department, El Centro, California.

PUBLIC HEALTH COORDINATOR: teaching and supervisory duties; 44-hour week; 4-week vacation, 2-week sick leave annually; salary $3,480. For details write to Grace Gummo, Director of Nursing, The Burbank Hospital, Fitchburg, Massachusetts.

QUALIFIED STAFF NURSE: voluntary agency with generalized service; excellent working conditions; varied experience; good salary. Apply to Director, Visiting Nurse Association of Stamford, Connecticut, 60 Guernsey Street, Stamford, Connecticut.

VISITING NURSE: VNA located in beautiful Santa Clara Valley; salary $255-$285, depending on public health preparation or experience; liberal car allowance (car essential); 40-hour week; one month vacation; sick leave; Social Security. Apply to Director, Visiting Nurse Association, 16 North San Pedro Street, San Jose, California.

GRADUATE NURSES: 5 for hospital work; must be licensed; meals and quarters furnished; salary open. Write to the Civil Service Commission, Room 310, City Hall Building, Norfolk, Virginia.

PUBLIC HEALTH NURSE SUPERINTENDENT: 5 years experience in a public health agency, 2 years of which shall have been in a supervisory or teaching capacity; degree in public health nursing and possession of a certificate in public health nursing; salary $310 a month with automatic increments to $372, inclusive. Write to the Municipal Civil Service Commission, Room 310, City Hall Building, Norfolk, Virginia.

SUPERINTENDENT OF NURSES: thorough knowledge of operating room and clinical procedure; 5 years responsible experience in professional nursing activities and graduation from an accredited school of nursing; training in isolation work; must be eligible to practice as a graduate nurse; meals and quarters furnished; salary $283 a month with automatic increments to $340. Write to the Municipal Civil Service Commission, Room 310, City Hall Building, Norfolk, Virginia.

SUPERVISOR OF NURSES and STAFF NURSE: salary for supervisor $4200-$4500 depending on qualifications and experience, starting salary for staff nurse $3340; car furnished or liberal allowance granted if driving own car; pension system, vacation, and sick leave. Contact Mr. Edward Peters, Acting Health Officer, City Hall, La Crosse, Wisconsin.

NURSING SPECIALTIES

The National Blood Program of the American National Red Cross continues to offer new professional nursing opportunities to nurses who can fill chief nurse and deputy chief nurse positions in blood centers. A college degree or at least two years of college work is required, as well as experience in teaching, administration, and public relations. Blood bank or operating room experience is desirable but not required. Inquiries should be directed to Mr. Norman A. Durfee, National Director, Personnel Services, National Headquarters, American National Red Cross, Washington, D. C., and reference should be made to the National Blood Program.

QUALIFIED PUBLIC HEALTH NURSE: new health center; 90 miles from New York City; salary $3,250-$3,550; official car; good personnel policies. Apply to Mr. Michael J. Reddy, Court House, Monticello, New York.

PUBLIC HEALTH NURSES for positions in urban and rural agencies, official and private, in various parts of the country; no fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57 Street, New York 19, N. Y.

PUBLIC HEALTH STAFF NURSE: visiting nurse association, Philadelphia area; excellent personnel policies; salary based on education and experience; association car or mileage. Write to Director, Visiting Nurse Association, 409 Cherry Street, Norristown, Pennsylvania.

STAFF NURSE: generalized public health nursing program established over a 10-year period; salary $250-$297, depending upon qualifications and experience. Apply to Director, Lawrence County Health Department, Lawrenceville, Illinois.

SCHOOL NURSE: must qualify for public health nursing certificate in the state of Illinois; salary range from $3,000 to $3,600 for 10 months, depending on training and experience; excellent working conditions. Write to B. F. Shafer, Superintendent of Schools, Freeport, Illinois.

STAFF NURSE: wanted immediately for generalized public health nursing program established over 38 years; starting salary $210 a month; car provided: 1 month vacation with pay after 1 year; sick leave; retirement plan. Apply to Director, Glen Cove Visiting Nurse Association, Inc., 50 Glen Street, Glen Cove, New York.

PUBLIC HEALTH NURSES: New York City Department of Health; immediate appointment on provisional basis; generalized service includes maternal and child care, school health and communicable disease control; starting salary $2650, 37-hour week, liberal vacation and sick time allowance, pension rights; inservice training; applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, N. Y.

PUBLIC HEALTH NURSES: generalized family and community program, including school health; $3,527-$4,005 a year; training program open to graduate nurses, 20 to 30 years, $3,268-$3,541 a year, trainees take academic work at university while gaining paid experience in field; 40-hour week; liberal vacations and sick leave; pensions; educational leave; inservice training. Apply to Detroit Civil Service Commission, 735 Randolph Street, Detroit 26, Michigan.

STAFF NURSES: generalized program in combined city-county unit; 270,000 population; retirement plan, vacation, and sick leave; $45 a month travel allowance on own car; requirements: registration in Kansas, completion of a year's approved program of study in public health nursing; nurses with or without experience considered; salary range $275-$313 a month; public health training center. Write to M. Leon Bauman, M.D., Director, Wichita-Sedgwick County Department of Public Health, 407 City Building, Wichita, Kansas.

STAFF NURSES: generalized, urban, rural program; salary range $2,756-$3,156 depending on qualifications and experience; liberal personnel policies. Apply to Visiting Nurse Association, 20 Maple Street, Springfield, Massachusetts.

QUALIFIED NURSES: generalized public health nursing program; 5-day, 40-hour week; retirement plan; Social Security; beginning salary $3,240; car optional; good personnel policies. Write to Mary I. Breneman, Director, Visiting Nurse Association, 1008 S. W. 6th Avenue, Portland 4, Oregon.

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NEWS

• The University of Michigan Fifth Annual Conference on Aging will be held in Ann Arbor, July 24-26, 1952. Housing the aging will be discussed, including such topics as types of housing and living arrangements, architectural designs and costs, hygiene and safety standards, social and economic aspects of housing, auxiliary services. Write to Dr. Wilma Donahue, Institute for Human Adjustment, Room 1510, Rackham Building, Ann Arbor, for conference registration material.

• A workshop in health education will be held June 17-28, 1952, at Trenton State Teachers College for junior and senior high school personnel responsible for the health supervision and instruction of pupils. The project is sponsored by the state departments of education and health, nonofficial organizations, and professional associations. The New Jersey Tuberculosis League and its affiliates are underwriting the costs of the workshop.

• Travelguide, Inc., announces a nine-day post-Biennial conducted tour to Puerto Rico, and St. Thomas and St. Croix in the Virgin Islands. For information about this trip write to Friendship Tour, P. O. Box 63, Radio City Station, New York 19.

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